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BARRIERS TO HEALTH CARE/CHILDREN'S HEALTH

HEARING

BEFORE THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

NINETY-NINTH CONGRESS

SECOND SESSION

ON

REVIEW OF ACCESS TO HEALTH CARE FOR THE POOR AND UNINSURED AND IMPROVED HEALTH FOR AMERICA'S CHILDREN

JULY 16, 1986

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BARRIERS TO HEALTH CARE/CHILDREN'S HEALTH

WEDNESDAY, JULY 16, 1986

U.S. Senate,
Committee on Labor and Human Resources,
Washington, DC.

The committee met, pursuant to notice, at 10:18 a.m., in room SD-430, Dirksen Senate Office Building, Senator Orrin G. Hatch (chairman) presiding.

Present: Senators Hatch, Kennedy, Kerry, Thurmond, Simon, Grassley, Dodd, and Nickles.

Also present: Senator Arlen Specter.

OPENING STATEMENT OF SENATOR HATCH

The Chairman. Over the years, in this committee, we have had the privilege of witnessing some of the tremendous strides that our Nation's health care system has taken. We have seen little babies who were brought back from the brink of death by modern miracles, certainly by liver transplant surgery, which just could not have been done a few years before. We have learned how monoclonal antibodies are conquering some cancers. We have heard how costly and literally heart-stopping open-heart surgery is being avoided through angioplastic techniques.

We have participated in new advances in health promotion by authorizing a network to promote preventive research. And through the magic of increased competition, spurred by such committee efforts as the promotion of generic drugs, we have seen more and more affordable health care provided to more people than ever before in our country's history.

However, as we marvel at these advances, we have to admit that our system of health care is not perfect. After all, how could any system involving 230 million Americans and the expenditure of $1.4 billion per day be perfect? But some of the lapses have to trouble us as policymakers entrusted with promoting good health for Americans who have to face these problems.

Unfortunately, infant mortality, for instance, persists at an unacceptably high infant level in some regions of our Nation. Also, many Americans are not receiving adequate health care services because they just cannot afford them. It has been estimated that up to 35 million people are either uninsured or underinsured.

Hospitals and health care providers throughout the country maintain that uncompensated care for these individuals poses for them severe financial difficulty.

As we confront these problems, everyone can agree on the goal—affordable, quality health care for all Americans. That is the easy part. The hard part is to agree on the solutions, and the extent to which the Federal Government is responsible for finding those solutions.

That is illustrated by two approaches to closing the gaps in our current health care system. President Reagan, for example, acknowledged both these gaps and the capabilities of the private sector in his 1986 State of the Union Address. He called on HHS Secretary Otis Bowen to report by the end of the year on how the private sector and Government can work together to address the problem of affordable insurance for catastrophic illness.

The President's directive set some wheels in motion. Meetings are being held throughout the country. Solutions are being debated. Ideas are being generated. And by the end of the year, we will probably have a report on most of them. But then we already have a series of creative options to review that involve new ways of tapping the full promise of our health care system.

How about alternative delivery sites for care? Could we repeat the success of IRA's in health care? Let us look into vouchers for senior citizens to purchase private health insurance. And then there are the efficiencies to be offered by expanding home health care programs.

In contrast, my good friend Senator Kennedy has introduced legislation which he considers part of the answer to our medical care woes. And he has had a dramatic imprint on health care all over this country in the many long years he has served here. And I can tell you from the letters that I have received that he has set a whole different set of wheels in motion—sometimes, I think, in reverse.

Nevertheless, the writers recoil at proposed Federal mandates of private health insurance—a matter which heretofore has always been regulated by the States. They warn that the proposals will inevitably result in higher premiums for health insurance for everyone, rich and poor alike. And they caution that many small businesses may not be able to shoulder the burden of added cost and regulation.

For example, under his legislation, the Federal Government would require employers to continue whatever health benefits they provide for 4 months after an employee is laid off.

We should remember that American business pays for 85 percent of America's private health insurance. Instead of killing the goose that has laid the golden health care egg, we should be exploring ways to make it easier for businesses to provide health care coverage to the 75 percent of the uninsured who are members of the working family.

We do have differences that continue with regard to children's health. Here again, we all agree on the goal—that every infant has the best possible environment to mature in—but again, we probably do not agree on the extent of the problem or the solutions.

During the Reagan administration infant mortality decreased by almost 20 percent. And while the infant mortality rates for blacks are still higher than whites, from 1980 to 1983, they fell almost twice as fast.

While I am a strong supporter of prenatal care for women, and I agree that current numbers are still too high, there is no simple solution for this complex problem—a problem rooted in poverty, poor education, a breakdown in the traditional family, and substance abuse by mothers during pregnancy.

As I said earlier, we all agree on the goals of improved access to affordable, quality health care. I agree with my more liberal friends that the Federal Government must provide part of the solution to these problems. But I also believe that the Federal Government is part of the problem.

As Michael Becker, of Citizens for a Sound Economy, recently testified,

> Twenty years of increasing government control of medical care have presented a sorry picture: costs rise, quality falls, inadequate coverage is provided, and freedom of choice is reduced.

I do not think the picture is quite that bleak, but I do think that instead of simply spending more Federal money placing bigger burdens on corporate America, small businessmen and women, and interfering with State governments as they attempt to meet the needs of their citizens, we ought to work together to tap the full potential of our private health care system.

I do look forward to hearing the testimony of today's witnesses and their recommendations as to how we might do just that.

I might also add that there is nobody on this committee who respects my colleague Senator Kennedy more than I do. I have had ten years of butting heads with him, and he has taught me a great deal. He raises many issues and the introduces a broad range of legislation, and he has created a tremendous public debate throughout this many years of very effective public service. I intend to look at everything that he suggests, and of course, look at everything that is suggested here today. We will then see what we can do. The Labor and Human Resources Committee has done a lot in public health over the last number of years—even over the lifetime of its existence. We intend to do much more.

Let us turn to Senator Kennedy.

OPENING STATEMENT OF SENATOR KENNEDY

Senator **Kennedy**. Thank you very much, Mr. Chairman.

I want to first of all say how delighted we are to have the television camera from the Senate Republican Conference to record these hearings for posterity, and we are glad that they are here to join us this morning.

I am pleased to participate in this hearing on barriers to health care and children's health, which Senator Hatch has graciously consented to hold at my request.

Our hearing today focuses on two key issues: access to essential health care for the poor and uninsured and improved health for America's children. Earlier this year, I introduced legislation on access for the poor and today I am introducing two bills to make health care more available to our youngest citizens and their mothers.

I look forward to the comments of the knowledgeable witnesses appearing before us today.

ACCESS

The legislation before our committee—S. 2402, the Access to Health Care Act of 1986—embodies a bipartisan, four-point initiative to deal with one of the most serious health problems facing the Nation—the inaccessibility of health care for millions of our fellow citizens. Along with its counterpart in the Senate Finance Committee, S. 2403, this legislation was recently introduced by myself, Senators Durenberger, Heinz, and Riegle. It is supported by a broad coalition of groups dedicated to the achievement of adequate health care for the American people. A companion bill has been introduced in the House by Congressmen Stark and Gradison.

The sponsors and supporters of these bills are united by the conviction that we face a true crisis in health care which threatens to deny millions of the American people access to the essential health care they need. This crisis in access to essential health care has two causes and you don't need an EKG or even a stethoscope to diagnose them. Too many Americans have no health insurance to pay for the care they need. And too many hospitals may soon be forced to shut their doors to those who cannot pay.

Thirty-seven million Americans—one out of every six citizens—have no health insurance at all. Since 1980, the number of persons without such coverage has soared by 42 percent. Over the last decade, the percentage of children without health insurance has doubled from 9 percent of all children to 18 percent of all children. And 25 percent of women in the key child bearing years of 18–24 have no coverage.

At the same time, hospitals face a growing burden in providing care for the seriously ill who cannot pay. Between 1980 and 1984, the cost of hospital charity care doubled, from $2.8 billion to $5.7 billion. In the new world of hospital competition, even the most compassionate and committed institutions will soon face a cruel choice between rationing health care for the poor or bankruptcy for their institutions.

According to a recent study sponsored by the Robert Wood Johnson Foundation, 1 million Americans every year are refused health care because they cannot pay, and an additional four million do not even seek care they need, because they know they cannot afford it.

These bills propose four specific steps to deal with this crisis.

1. Health insurance for the unemployed

Employers offering health insurance to their workers will be required to extend coverage for four months after a worker is laid off, as long as the worker agrees to pay the same premium he was paying on the job. In addition, employers will be required to permit open enrollment for family coverage when a worker in a two-worker family is laid off and loses health insurance.

Seventy percent of the unemployed have been without work for less than 4 months and 50 percent of all laid-off workers are reemployed within 4 months after the layoff. Because they have lost their employment-based group insurance and can't afford an individual policy, they are forced to go without coverage—and gamble that a medical catastrophe will not strike them or their loved ones.

For half a century, the unemployment insurance system has protected Americans against the income loss arising from short-term unemployment: it is time to provide the same protection against the potentially ruinous cost of a major uninsured illness.

Solving this problem is not a budget-buster. The Congressional Budget Office estimates that as many as 10 million workers and their dependents would benefit from enactment of this proposal. There would be no additional Federal outlays, and the maximum cost to employers would be $1.5 billion, less than seven hundredths of 1 percent of current payroll.

2. Insurance pools for the uninsurable

Hundreds of thousands of Americans are not poor but have no access to employment-based insurance and cannot obtain insurance because of their poor health status. Many of these are parents who face the emotional burden of caring for a chronically ill child—a burden that should not be compounded by the fear of financial ruin.

Our proposal requires States to establish pools of comprehensive insurance for all residents, regardless of health status. The pools will be largely self-supporting, but if the premiums exceed 150 percent of the customary cost of individual policies, all employers and insurers with more than 20 workers offering employment-based health insurance would contribute to the pool. Based on current experience, the cost of the premium subsidy for participating employers will be minimal, between 50 cents and $1.40 per employee per year.

Nine States—Connecticut, Florida, Indiana, Minnesota, Montana, Nebraska, North Dakota, Rhode Island, and Wisconsin—already offer similar pools to their residents: 2 million Americans could benefit if all States offer them.

Almost all States have mechanisms to provide auto insurance for otherwise uninsurable motorists. Citizens burdened by the cost of serious illness deserve help at least as generous in obtaining the coverage they need.

3. Hospital care for the uninsured

Charity care for the poor and the uninsured is a traditional mission of community hospitals. For decades, the cost of care for those who cannot pay has been financed out of earnings from paying patients. In today's highly competitive health care system—created in part by Government mandated cost controls imposed in recent—years—hospitals are increasingly unable to subsidize those who cannot pay. Competition has been an important innovation in the health care system, but it is false economy to deny health care to those who cannot afford it.

Our proposal requires States to establish mechanisms to finance essential health care for those who cannot pay. The traditional subsidies that are now drying up must be replaced with explicit help.

New York, New Jersey, and Florida already have such mechanisms in place. Enactment of this proposal will assure that patients with serious illnesses can obtain the care they need. Hospitals must be able to fulfill their traditional mission of care and open their doors to all who need it, free from the fear that bankruptcy will close their doors to all.

4. Health insurance for small businesses

Three-quarters of those without health insurance are workers or dependents of workers—and three quarters of these in turn work for small businesses.

Owner-operators of small unincorporated firms face a significant tax disincentive in providing health insurance for their workers. Employer-paid health insurance premiums do not count as taxable income to the workers, but—because the owner is not an employee—he is not entitled to deduct the cost of his own health insurance as a business expenses. Our proposal encourages small businesses to provide insurance to their workers by enabling the owner to deduct the cost of his own personal insurance as a business expense if his workers also participate in the plan. The tax expenditures associated with this proposal would be about $200 million per year as compared to current law and substantially less compared to the Senate tax reform bill.

Small businesses are also less likely to offer health insurance because of higher marketing and administrative costs, which require them to pay 40 to 50 percent more than large firms for comparable coverage. Our proposal requires the Secretary of HHS to conduct studies and demonstrations of methods to reduce the cost of health insurance to small businesses.

Enactment of the measures we are proposing is affordable and achievable within the constraints of the federal budget and the capabilities of the nation's health care system. It will not solve all the problems of the current system, but it will bring decent health care to millions of our fellow Americans who find it out of reach today.

CHILD HEALTH BILLS

Over the last decade, the number of children without health insurance has nearly doubled from 6 million to 11 million children. If children without insurance for part of the year are also counted, the number has increased from 12 million to 17 million children. This is 25 percent of all children. Nationwide, over 9 million women of child bearing age also have no health insurance and 25 percent of all women in the key child bearing years, 18–24, are not covered.

The disadvantages of inadequate health care begin early in life. They begin even before birth. Lack of health care during pregnancy increases the risk that a baby will be below the normal birthweight by 300 percent. Low birthweight babies are at the greatest risk of becoming infant mortality statistics. We should not stand by while the United States remains 15th in the world in its infant mortality statistics—behind Portugal, Italy, Finland, Japan, and ten other countries.

Earlier this year, I introduced along with a larger bipartisan group of senators, introduced a bill (S. 2333) that will make health care more available to pregnant women and their infants. The bills

I am introducing today will extend the initiative of that earlier bill.

The first of the two bills we are introducing, the Children's Health Care Act of 1986, will allow State to extend Medicaid benefits to as many as 3 million children who live in poverty households around the country with incomes below 100 percent of the Federal poverty level. The bill will permit States to separate AFDC eligibility from Medicaid eligibility so that it will no longer be necessary to enroll in AFDC in order to be eligible for Medicaid. Under the terms of the bill, States will have the option of offering Medicaid to children to any age up to age 18 as long as they live in poverty households. Because a healthy family is the best environment for a healthy child, States will also be able to enroll the parents of those children if they chose to do so.

Over 3 million children and their parents could benefit from this bill. Though Medicaid was intended to fill in the health insurance gap for people with poverty level incomes, today less than half of the women and children who live in poverty households are eligible for Medicaid coverage.

The Southern Governor's Association has recommended the change in the law I am introducing today. The National Governor's Association unanimously endorsed it. It is time for Congress to do its part.

This bill will also mandate that State refer children who lose Medicaid to other low cost or no cost providers. And it requires that States refrain from arbitrary restrictions in services to children and reimburse for all visits necessary to complete the health screening requirements of the American Academy of Pediatrics. The bill will also establish case management demonstration programs for children with chronic illnesses.

Earlier this year, we introduced S. 2333 to extend a similar option to States to provide Medicaid coverage for pregnant women and their infants. That bill was introduced with solid bipartisan support. It was clearly understood by all the cosponsors that nothing is gained, and a great deal is lost, when health care is denied to pregnant women and their newborn infants. The toll we pay in the use of prolonged and expensive hospital intensive care services and in children with lifetime disabilities is painfully high. I cannot think of a better example where an ounce of prevention really does equal a pound of care.

Is there anything that is gained by the current gap in Medicaid coverage for women and children? In these years of obsession with Government spending, it is reasonable to ask whether this policy even saves money. Even by this miserly yardstick, this policy fails.

Children comprise 50 percent of all Medicaid recipients. Yet they account for only 14 percent of Medicaid expenditures. Women are 25 percent of the recipients in the program. Yet they account for only 12 percent of the costs. The average cost of providing Medicaid service to a child was $400 per capita last year. By contrast, the average per capita cost of providing medical services last year was four times as large.

Of course, cost is not the principal issue here. But the fact remains that children are not expensive to provide for. A small investment can go a very long way.

S. 2333 will go a long way to reducing barriers to maternal health services and improving our infant mortality rate. But it will not eliminate the barriers to health care for poor pregnant women. Other barriers, including delays in eligibility determinations and arbitrary limitations on numbers of medical visits and services, endanger the tremendous gains which can be made by expanding Medicaid eligibility. The bills we are introducing today would provide for accelerated enrollment of pregnant women into the Medicaid program and remove limitations of amount, scope, and duration on medical services for pregnant women. It would also provide expanded services for those pregnant women who are at highest risk of a poor birth outcome.

These amendments will increase the odds that prenatal care will begin in the first trimester of pregnancy rather than months later—after eligibility has been determined. They will also ensure that pregnant women receive all the services ordered by their doctors. These changes should greatly increase the odds that expanding Medicaid services to poor pregnant women and their infants will succeed in reducing the great cost and human toll caused by low birthweight and infant mortality.

This bill will also ensure that title V maternal and child health clinics get reimbursed fully by Medicaid when they provide services to pregnant women enrolled in Medicaid. And it will improve the reporting done by title V clinics about the service they provide.

These bills could benefit 3 million women and 3 million children living in poverty households around the country. Children, those little people who are the hope of our future, deserve better than what they are receiving in 1986. The first step is to ensure their mothers access to decent health care during their pregnancies. The next step is to provide for the children themselves.

One of the most serious health problems that affect children of all backgrounds and economic classes is injuries. Injuries account for 50 percent of all deaths of children over the age of 1 and two-thirds of all deaths of children over the age of 15. In fact, injuries are responsible for more deaths among children than all diseases combined.

Today, I am also introducing a bill to address the important area of children's health. It will direct the Secretary of HHS to report and make recommendations on the problem of injuries to children and will authorize a center for injury control within the Center for Disease Control. This center will support research on injury control and promote state activities to reduce the toll of injuries.

I hope our colleagues from both sides of the aisle will join in supporting these very sound proposals.

I thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Kennedy. I can see that you feel very deeply about this subject.

Senator Simon?

Senator SIMON. Thank you.

I am here primarily to learn, Mr. Chairman. I have concerns. Senator Kennedy talked about people on unemployment compensation. The reality is, only 29 percent of the unemployed today are even covered by unemployment compensation. We have some problems in our society.

And if I may, the one graph in back of you, Mr. Chairman—I do not know who put these graphs up—but what does that graph, "Percentage of People With Third-Party Coverage of Medical Expenses"——

The CHAIRMAN. The source is the Center for Health Administration Studies at the University of Chicago.

Senator SIMON. Well, the University of Chicago is a great source, but——

[Laughter.]

Senator KENNEDY. The chart is provided by the Senate Republican Committee.

Senator SIMON. Well, by implication, we are suggesting that almost 100 percent of our population has some kind of coverage.

The CHAIRMAN. This was put together by Labor and Human Resources Committee majority staff. [Laughter.]

Even though I have to admit it is difficult to be a Republican in Washington, DC, but nevertheless, it is accurate.

Senator SIMON. Well, it clearly is wrong to suggest that almost 100 percent of the people in our country have some kind of coverage of their medical expenses. And I do not know where the university——

The CHAIRMAN. Well, what it does show, Senator, is that the low-income people, about 85 percent of them are covered. That means there are 15 percent who are not. This chart clearly shows some are not covered as I stated in my opening remarks.

Senator SIMON. I would be interested in someone from my staff or your staff or the University of Chicago explaining that graph to me, because I think it implies something that is not accurate.

The CHAIRMAN. All right. We will get that done.

Thank you.

Senator SIMON. I have no further statement. I am concerned about this problem. I think we have to provide help to people that we are not providing.

And I am sorry I was not here for Senator Specter's statement.

The CHAIRMAN. We will be happy to provide you with all the literature from which that came, and you can then draw your own conclusions.

We will keep the record open for the statements of any Senator on the committee who would like to put them in.

[The prepared statement of Senator Dodd follows:]

PREPARED STATEMENT OF SENATOR CHRISTOPHER J. DODD

Senator DODD. Mr. Chairman, I am delighted that the committee this morning will hear from witnesses on two pressing health issues: The plight of the uninsured and the underinsured, and the problems of child health care in this country.

Obviously, Mr. Chairman, the two issues are related. If parents do not have health insurance or do not qualify for Medicaid, their children cannot obtain health care either. I have some questions for the first panel on this serious problem.

The second portion of this hearing, focusing on the problems of child health care could encompass a wide range of issues and could take many days. I understand this moring we will be looking primarily at the emergency posed by our recent failure to make progress in reducing infant mortality.

In my State of Connecticut, non-white infants, many of whom are born to teen mothers, are twice as likely to die in the first year of life as white infants. Over 10 percent of all births in Connecticut are "teen births." For black and Hispanic teenagers, that figure is much higher: some 23 percent of all minority births involve adolescent parents. Teenage mothers in Connecticut are four times more likely than older mothers to lack adequate prenatal care. And, as our witnesses are certain to emphasize this morning, malnutrition and lack of prenatal care can result in the birth of low birth-weight babies who are at greater risk of disability or death.

According to the March of Dimes, we have made no substantial progress in this country in the past twenty-five years in preventing the birth of low-birth-weight babies. We have made significant technological advances in keeping such infants alive once they are born. But to have lagged so far behind in taking the preventive steps necessary to reduce the incidence of premature and at risk births is truly shocking.

The Southern Governor's Association under the leadership of Governor Riley has completed a landmark study on infant mortality, with a comprehensive set of legislative remedies. As a result of their efforts, several bills have been introduced in the Senate to expand the Medicaid Program allowing States to combat the problem. I am pleased to have cosponsored this legislation, S. 2333 and S. 2288 and look forward to hearing the testimony of our distinguished witnesses on what else we might be doing to address this alarming state of affairs.

I would also like to bring another child health issue to the committee's attention. While infant mortality ranks as the biggest risk before the first year, the most pressing health problem facing children between the ages of 1 and 18 is injuries. At a Senate Children's Caucus forum two years ago we learned that injuries are biggest killer and disabler of children. Virtually one-half of all youngsters between the ages of 1 and 14 who die this year will die in auto accidents, fires, falls from open windows, and drowning incidents. More teenagers will be killed in car crashes during 1986 than any other group of Americans. And for every child killed in an accident, thousands more will be disabled—sometimes permanently.

The tragic cost of injuries in human terms can never be computed. But the cost in hospital bills can be. According to the Consumer Produce Safety commission, it costs close to $30,000 to treat a child scalded by tapwater. With 4000 victims a year, the total in hospital expenses is some $112 million.

Mr. Chairman, I would be pleased to share with committee members some of the excellent testimony the Senate Children's Caucus heard two years ago on this subject. We held the forum at Children's Hospital National Medical Center here in Washington, D.C. and heard from children, doctors and nurses, Governor Brennan from Maine, and public health experts. As a result of our forum, childhood injury research is now being conducted at the Center for Disease Control and the National Institute of Child Health and Human Development. That funding runs out at the end of FY87. So, I hope the committee will be able to review the preliminary results of that research then, and decide on what further steps are necessary to combat injuries.

The CHAIRMAN. Senator Thurmond, we will turn to you.

Senator THURMOND. Thank you very much, Mr. Chairman.

Today, I would like to bring to the attention of this committee legislation S. 2333, which represents a major initiative toward reducing the high infant mortality rate of this Nation.

The United States has a higher infant mortality rate than many other developed countries, such as Sweden, Japan, Norway, Denmark, France, Spain, Canada, East Germany, and the United Kingdom. Recent statistics indicate that for every 1,000 live births, approximately 11 babies will die before the age of 1 year.

In my home State of South Carolina, the problem is greater, with 15 deaths for every 1,000 live births. Mr. Chairman, two-thirds of infant deaths occur in the neonatal period, the first month of life. The factor most commonly associated with these newborn deaths is low birth weight. The smaller the baby, the poorer the chances of healthy survival.

A low birth weight baby is more likely to need costly special care. In addition, low birth weight babies also have significantly higher rates of rehospitalization.

To address the problem of low birth weight infants, the Medicaid system needs to be improved. This legislation is designed to accomplish that goal, and Senator Kennedy has joined me in introducing this particular legislation.

Mr. Chairman, Medicaid plays a critical role as the Nation's principal financing source for the health care of mothers and children who are financially unable to help themselves.

However, as many as 3.4 million poor pregnant women a year are denied vital prenatal care because they are ineligible for Medicaid. Without proper prenatal care, many unnecessarily low birth weight babies are born who need significant ongoing medical attention. This, of course, means additional medical expenses. In many cases, the high medical expenses associated with low birth weight babies drain the financial resources of the mother until she then becomes eligible for Medicaid.

Medicaid then must pick up the tab for the expensive institutional medical treatment. Mr. Chairman, what is needed, and what this legislation provides, is an approach geared toward preventive medicine.

Under this legislation, the Medicaid law would be amended to allow States with Aid to Families for Dependent Children, AFDC, standard of need above 50 percent of the Federal level, to target Medicaid assistance to pregnant women and infants, without the State also being required to raise AFDC payments to this group. This action would be completely optional with the States.

The idea behind this change is to remove a financial obstacle from many States that want to provide a comprehensive maternity and infant health care package to indigent women, but have not done so because of the high cost of State matching requirements for AFDC payments.

Mr. Chairman, the cost of this bill will be $100 million to the Federal Government. This amount has already been added to the budget plan to cover the cost of the expansion after the Budget Committee gave it careful consideration.

Mr. Chairman, I want to emphasize that these moneys spent now will prove cost-effective over the long run. The American Academy of Pediatrics reported in 1984 that for every dollar spent on prenatal care, $2 to $10 can be saved down the road. An ounce of prevention is worth a pound of cure.

This is the approach of this legislation, and I would urge my colleagues to support this bill at the appropriate time. I wanted to bring it to the attention of the Committee because I feel it is a very important piece of legislation.

The CHAIRMAN. Well, thank you, Senator. I appreciate it. It is my privilege now to welcome my colleague, Senator Arlen Specter, to the Senate Committee on Labor and Human Resources. Senator Specter has introduced legislation with basic worthwhile goals to reduce the tragedies of infant mortality.

So I look forward to learning from you, Senator Specter, just what you think we ought to do in this area and what this legislation will do for children's health in this country. Thank you again for joining us. If you would, please begin.

STATEMENT OF HON. ARLEN SPECTER, A U.S. SENATOR, FROM THE STATE OF PENNSYLVANIA

Senator SPECTER. Thank you, Mr. Chairman.

I appreciate the opportunity to appear this morning to testify in support of Senate bill 1873, which I introduced on November 21, 1985.

Mr. Chairman and members of the committee, this legislation was introduced because of statistics which I noted from 1982, which showed that Pittsburgh, PA, led every other city in America with the rate of 29.7 black infant deaths per 1,000 live births, while the rate for white infants was 10.1 deaths per 1,000 live births.

And it seemed to me to be an absolutely intolerable situation that a major American city like Pittsburgh should have three times as many black infant deaths as white infant deaths. And, having focused on that, my staff and I then convened a series of meetings in Pittsburgh, one on August 6, 1984, where I met with representatives of the Pittsburgh Black Women's Health Network and other health professionals at the Alma Emery Health Center. A subsequent meeting took place a few months later on October 22, 1984. And I might say, Mr. Chairman, that the 1982 statistics became available only shortly before those meetings were convened. And we have had a series of meetings in Pittsburgh and have had interested parties get together to structure the bill, Senate bill 1873, which I have introduced.

The thrust of this legislation recognizes the need for a concerted attack on the shocking problem of infant mortality in certain segments of our population, and it proposes a response on a partnership among Government health care professionals and individuals in addressing infant mortality.

It allows nonprofit community-based health organizations to apply for grants to develop and implement health education and outreach efforts to increase public awareness and the use of health promotion strategies, and it directs the emphasis for targeting efforts to be placed on groups with poor health status indicators, such as high infant mortality rates, and it recognizes certain cultural and lifestyle realities as the target population grew.

It further mandates that community resource panels include consumers, representatives of local government, the private sector, health professionals, the board of education and the clergy, all to be involved in the implementation of the program.

Simply stated, the experience has been that among blacks and Hispanics and other disadvantaged, there isn't basic information about the need for appropriate nutrition during prenatal stages care in delivery and care of the children immediately after birth.

There is, Mr. Chairman, an enormous problem nationally, where infant mortality claims some 51,869 deaths in the most recent yearly statistics available, and among those, 28,301 are white, 11,242 are black, and 12,326 are categorized as others.

I certainly commend my colleague, Senator Thurmond, and the cosponsors of the legislation which he has introduced on the problem generally, but it seems to me that there has to be some special targeted attention to this really shocking situation on black infant mortality.

I know, Mr. Chairman, that you hail from Pittsburgh, PA. You know the city very well, and I know that you and all the members of this committee share my sense of outrage at what is happening.

I would urge this committee to address the problem generally, as I know you will, but there can be little doubt about the emergency situation with respect to the particular problem of black infant mortality, and it requires an immediate response.

Thank you, Mr. Chairman.

The CHAIRMAN. Well, thank you, Senator.

Are there any questions by anybody on the committee?

Senator KENNEDY. As I understand, one of the features of your bill is dealing with information for community health service programs; is that correct?

Senator SPECTER. That is a central thrust, Senator Kennedy. You find many teenage girls, 13, 14, 15, who really do not know what is happening to them. And they are aware of the fact that they are pregnant, but they do not know what they have to do by way of nutrition to take care of the child that they are carrying; they do not know what to do about prenatal medical care; they do not know what to do about delivery; they do not know what to do about caring for their children immediately afterward. It is significantly a matter of basic education.

Senator KENNEDY. Even when they find that out, what is the delivery cost, for example, in Pittsburgh—is it about $2,200, $2,500?

Senator SPECTER. Senator, I do not know what the delivery cost is. I would guess it is a lot less than $2,200, however, for the category of individuals we are talking about.

Senator KENNEDY. Well, there were recently some hospitals, in both Philadelphia and Pittsburgh that threatened to close their doors for delivery unless patients could pay cash before coming in.

Senator SPECTER. Maybe even some other major American cities like Boston.

Senator KENNEDY. Sure. That is part of the problem, then. Are you going to give us a hand in supporting legislation that will help those hospitals?

Senator SPECTER. You bet.

Senator KENNEDY. So, shall we put you down as a cosponsor for the legislation?

[Laughter.]

The CHAIRMAN. If I were you, Senator, I would read it before cosponsoring it.

Senator SPECTER. Now, that question was directed to me, Mr. Chairman.

Are you prepared to cosponsor S. 1873, Senator Kennedy?

Senator KENNEDY. It is fine with me. Quite frankly, I think with $20 million, I would rather provide it for services for individuals, but I am all for the information.

What we are really attempting to do in the Child Care Program is to make sure that those pregnant girls that you are worried about are going to be able to get treated once they have the information. That seems to me to be a key part of the problem, particularly when we are finding many hospitals that cannot and will not treat them because of the financial pressure. Those are two issues we are attempting to deal with in the legislation.

So you can put me down as a cosponsor in terms of providing information. I think that that is a useful effort and initiative, but it really does not deal with the basic issue and question, and that is whether the hospitals are going to have the resources to provide essential care, or whether the people who are below the poverty line, who are the expectant mothers, who will not get coverage even once they know it, will be able to get eligibility for coverage. And that is one of the bills that we are considering here today.

So I would hope that perhaps you might take a look at this legislation, too, and see if we cannot complete the job—let them know about the problem and then make sure, if it is expectant mothers, and they are not on Medicaid but they are below poverty, that they are going to be able to get the coverage, and give the hospitals some assistance to make sure they are going to be able to do it. It seems to me that that is at least a logical extension of what you are attempting to do.

Senator SPECTER. Senator Kennedy, I am prepared to sign on as a cosponsor to the Thurmond-Kennedy bill.

Senator KENNEDY. Now, you understand the distinction on this—I mean, we welcome you on that. That is a much more limited group. We can give you the cost of it. The CBO now talks about—what is it, Strom—about $25 million?

What I am talking about now is trying to ensure that if States want to provide this well-baby care for expectant mothers below the poverty line, and if the States make that determination, that they are going to be able to do it. That is what we are talking about.

Senator SPECTER. Which bill are you talking about, Senator Kennedy?

Senator KENNEDY. S. 2333.

Senator SPECTER. I would respond, though, Senator Kennedy, to the priorities which you establish. I do not know that it is especially useful to debate which comes first, the conception or the delivery. But I would say that nothing is a higher priority than acquainting a pregnant woman with the need for nutrition after she conceives, and with what she has to do during that 9-month period before she needs the hospital for delivery.

I think there are many situations where there is already too much damage done before you come to the point of delivery. I quite agree with you that there has to be adequate medical care, but I do not agree that that takes precedence over some basic information for a 13- or 14-year-old young woman who is pregnant. They have to know what to do in prenatal care, and they have to know where to go, what hospitals to apply for.

There are some hospitals which may have closed their doors, but I think there are many hospitals which have not, so that it is an ongoing process.

Senator KENNEDY. Senator, you do not have any argument with me. I happen to be the author of the teenage pregnancy bill that passed the Congress and the Senate 8 years ago. And it is tragic. We provided about $10 million for that program. And I hope on that particular program that we will be able to get your help and support for adequate funding for it. It has provided important help and assistance for the problems, and it is a drop in the bucket. And part of the problem, I think, is that we are for legislation for a teenage pregnancy bill, looking like we are for it, and not providing the adequate resources to be able to do something about it.

I have no further questions, but knowing the interest of the Senator now, I will certainly look forward to finding ways that we can work together on the bill.

Senator SPECTER. I would be glad to do that.

The CHAIRMAN. Well, thank you, Senator. I think you make a lot of good points. We know that more needs to be done than just prenatal care to reduce infant mortality. There is substance abuse, nutritional problems, and a whole raft of other problems that I think we are concerned about. Unless we approach all of them, we are not going to solve the problem of infant mortality.

I appreciate the interchange you both have had here.

Are there any other questions?

Senator THURMOND. Mr. Chairman, I just want to commend the able Senator from Pennsylvania for his fine interest in this important matter.

Senator SPECTER. Thank you very much, Senator Thurmond.

The CHAIRMAN. Thank you, Senator Specter. We appreciate having you with us.

Senator SPECTER. Thank you, Mr. Chairman.

The CHAIRMAN. Now I am going to proceed to our second panel to accommodate Senator Thurmond. Our second panel will discuss our Nation's efforts to reduce infant mortality and increase access to health care for our nation's children.

First, I am very pleased to welcome Mrs. Nancy Thurmond. Mrs. Thurmond, I would like to take this opportunity to commend you for your work with the March of Dimes, and I appreciate your willingness to present testimony on behalf of the Coalition of Healthy Mothers, Healthy Infants. I want to tell you that this is one of the great privileges that I have of working here in the Senate, is of course, without question, the privilege of working with your good husband, Senator Thurmond. And we feel particularly happy to have him on this committee. He has provided a great deal of support for the chairman and I think a great deal of leadership on this issue in the Senate as well. So I am pleased that I also am a cosponsor of his bill, the Medicaid Maternal and Infant Amendments of 1986.

Our second witness will be Dr. Bernard Guyer, Director of the Division of Family Services of the Department of Public Health in Boston, MA; and our final witness is Kay Johnson, representing the Children's Defense Fund.

We will begin with you, Mrs. Thurmond, first.

STATEMENT OF MRS. STROM THURMOND, ON BEHALF OF HEALTHY MOTHERS, HEALTHY BABIES COALITION, EDGEFIELD, SC; DR. BERNARD GUYER, DIRECTOR, DIVISION OF FAMILY HEALTH SERVICES, MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH, BOSTON, MA; AND KAY JOHNSON, HEALTH PROGRAM ASSOCIATE, CHILDREN'S DEFENSE FUND, WASHINGTON, DC

Mrs. THURMOND. Thank you very much, Mr. Chairman.

First of all, I would like to tell you how honored I am to be here. This is a very unique opportunity for me to appear before you, Mr. Chairman and your distinguished committee. In the past, the only testifying I have ever done is before Strom, so this is certainly a memorable occasion for me.

The **Chairman**. That is pretty formidable to everybody else, I will tell you that right now.

Mrs. **Thurmond**. And I must start out by saying that this is not "Thurmond versus Thurmond"; this is "Thurmond and Thurmond" this morning.

And as you know, Mr. Chairman, I am not the speaker in our family, although Strom insists that I do all the talking at home, but he does hold the longest filibuster record in the U.S. Senate—24 hours and 18 minutes—and I certainly will not compete with that record this morning.

First of all, Mr. Chairman, I want to thank Laurie Cooper, the executive director of the Healthy Mothers, Healthy Babies Coalition, for being with me this morning, and also Michael Tongour, who is Senator Thurmond's legislative director, and members of the legislative staff.

Senator **Thurmond**. Mr. Chairman, excuse me for interrupting, but as President pro tempore of the Senate, I have got to open the Senate in 8 minutes. I just want to apologize to my wife for leaving and not hearing her statement. I am sure she will make an excellent statement, and I will take great pleasure in reading it later.

The **Chairman**. Nancy, you just deliver it at supper this evening; I think he will really enjoy hearing it twice.

Mrs. **Thurmond**. I am going to deliver the statement just as Strom wrote it. [Laughter.]

As the mother of four children, one of whom is with us today, our daughter Julie, and an active volunteer in the Healthy Mothers, Healthy Babies Coalition, I would like to express my thanks for your national leadership, Mr. Chairman, in issues important to the American family and especially for your strong concerns and efforts to improve the health of and the health care for America's children.

I particularly appreciate this opportunity to speak to the Senate Labor and Human Resources Committee on the work being done by the Healthy Mothers, Healthy Babies Coalition to improve maternal and child health.

The United States has a higher infant mortality rate than many of the other developed nations of the world, such as Japan, France, Spain, Canada, and the United Kingdom. Recent statistics indicate that for every 1,000 births, approximately 11 American babies will die before their first birthday. These shocking statistics underscore the importance of the work being done by the Healthy Mothers, Healthy Babies Coalition.

This coalition is a public educational effort of 80 voluntary health professional and governmental organizations, including the American College of Obstetricians and Gynecologists, the American Nurses' Association, the American Red Cross, the Salvation Army, the March of Dimes Birth Defects Foundation, and the Departments of Transportation, Agriculture, and Health and Human Services.

The Healthy Mothers, Healthy Babies Coalition began in 1981 when representatives of these organizations met to discuss how to prevent infant mortality and how to improve infant health through better education for women, their families and health care providers.

The Healthy Mothers, Healthy Babies Coalition emphasizes preventive actions—proper nutrition, the avoidance of cigarettes, alcohol and drugs, and the importance of early and regular prenatal care—which every woman can put to good use to help assure that she will have a healthy baby.

On the national level, the coalition coordinates the programs of its member organizations and works to expand the availability of existing resources on prenatal health. On the State and local level, the Coalition has developed affiliate chapters for which it provides technical assistance and educational materials. Forty-seven States have Healthy Mothers, Healthy Babies Coalitions. Activities of the State coalitions range from special events to educate the public on the importance of prenatal care to efforts in support of various legislation.

As to legislative initiatives, I am proud that my husband shares my commitment to improvement of infant health and the prevention of infant mortality. Last year, Strom cosponsored legislation which would establish a National Commission to Prevent Infant Mortality. This Commission would identify and examine available Federal, State, and private resources to combat infant mortality and to recommend a comprehensive national policy designed to improve efforts to prevent infant mortality.

Last April, Strom, Senator Kennedy, Senator Hollings, and Senator Durenberger coauthored legislation to strengthen and improve Medicaid services to economically disadvantaged pregnant women and children. This legislation, S. 2333, would allow States the opportunity to further expand prenatal and postnatal health care benefits currently provided under the Medicaid Program. It is my understanding that this bill, which has strong bipartisan support, now has 39 cosponsors.

Last month, Strom coauthored health warning label provisions which were included in the National Institute of Alcohol Abuse and Alcoholism Reauthorization Act. One of the labels which would appear on all alcoholic beverages would read: "The Surgeon General has determined that the consumption of this product, which contains alcohol, during pregnancy can cause birth defects." Your committee, Mr. Chairman, unanimously approved this bill 3 weeks ago today.

The National Coalition has developed a variety of educational resources, including posters, brochures, resource directories, and public service announcements, which are made widely available. These educational materials are designed in particular for economically disadvantaged women. The coalition designed a series of six simple informational cards and posters on prenatal care—examples can be seen on my left. Over 7 million cards, including English and Spanish versions, have now been distributed across the country. Most recently, the coalition has developed and distributed a Food Wheel which teaches women to follow a more healthy diet during pregnancy. The response has been overwhelming. I have some samples of the Food Wheel here for your perusal.

Coalition-sponsored research indicates that for many economically disadvantaged women, preventive health care is not a priority. Pregnancy is not considered a health concern which requires medical attention. Often, women who fall below the Federal poverty level only seek health treatment when physical symptoms are acute.

Mr. Chairman, many groups and organizations like the Healthy Mothers, Healthy Babies Coalition are determined to improve health care for pregnant women and newborn babies and to meet the Surgeon General's goal of reducing the infant mortality rate to 9,000 by 1990. Without the efforts of organizations such as the Healthy Mothers, Healthy Babies Coalition, many women would never understand the relationship that exists between their own health and that of their babies.

For these reasons, we have found our work with the Coalition to be extremely gratifying and encouraging. The task, the work and the challenge ahead are monumental.

Our fervent hope and prayer is that one day soon, we will see that all babies are born perfectly beautiful and beautifully perfect.

Mr. Chairman, I thank you and the members of the committee again for this opportunity to give you our perspective about the important work of the Healthy Mothers, Healthy Babies Coalition.

The **CHAIRMAN**. Well, thank you, Mrs. Thurmond, for your excellent statement.

Let us turn to Dr. Guyer at this time.

Dr. **GUYER**. Thank you.

Senator Hatch, Senator Kennedy, members of the committee, I am Dr. Bernard Guyer, director of the division of family health services in the Massachusetts Department of Public Health, the State Title V Maternal and Child Health agency.

Thank you for the opportunity to testify on the importance of assuring adequate prenatal care in efforts to prevent low birthweight and reduce infant mortality. To aid in your deliberations, I would like to review the status of infant health in Massachusetts and update you on Massachusetts' initiative to reduce infant mortality, including the Healthy Start Program.

Massachusetts is extremely fortunate to have a healthy population and generally good indicators of maternal and infant health. In 1983, for example, we ranked eighth among the States for the best infant mortality rate with 9.1 infant deaths per 1,000 live births.

Massachusetts' infant mortality was the best among all major industrialized States.

In terms of low birth weight, Massachusetts ranked 16th best with an overall percentage of low birth weight of 5.9 percent.

Finally, Massachusetts ranked second among States in early prenatal care with 85.6 percent of all deliveries receiving care in the first trimester.

However, these overall indicators of good pregnancy outcome in Massachusetts obscure high-risk populations and areas of the Commonwealth.

For example, the infant mortality rate for nonwhites in 1983 was 14.1, nearly double the rates for whites. The low birth weight rate for nonwhite births was 10.1, again nearly double the percentage for whites.

And while 86.6 percent of white women received early prenatal care, only 76.1 percent of nonwhite and only 60.3 percent of nonwhite teenagers received early prenatal care.

I should also say in Massachusetts that we are fortunate to have an excellent system of health care for women and children, funded in part through the Title V Maternal and Child Health Services Block Grant and State maternal and child health appropriations. A network of 60 community health centers provides access to primary obstetric and pediatric care. We also have an excellent system of regionalized maternal care in the Commonwealth.

We were extremely concerned in 1981 when the infant mortality rate in Massachusetts rose to 10.1 infant deaths from 9.6 the previous year. This was the first increase in 9 years and the largest in 17 years. The increase prompted our Public Health Commissioner, Dr. Bailus Walker, Jr., to appoint a 19-member Task Force on the Prevention of Low Birthweight and Infant Mortality, chaired by Dr. Julius Richmond, professor of health policy research and education at Harvard University and a former U.S. Surgeon General.

The task force found gaps in rates of low birthweight and infant mortality among vulnerable populations in the State, as well as gaps in resources and services available to pregnant women, infants, and their families across the State. It concluded that there are unequal opportunities for infants to grow up healthy in the Commonwealth, and that these gaps must be closed if Massachusetts is to maintain and further its progress in preventing avoidable infant death and disability.

The task force called for maximizing the opportunity for every infant born in the Commonwealth to enjoy a healthy development.

I am submitting a copy of the full report of the task force entitled, "Closing the Gaps", with my testimony. In my oral presentation, though, I just want to focus in on one aspect, which is relevant to the earlier discussion.

In looking at gaps in access to the health care system, the task force found that although services are widely available, there are barriers to obtaining them in Massachusetts. For example, it found that in recent years, utilization of prenatal care has actually levelled off and begun to decrease slightly.

Second, it found that approximately 6,000 women were uninsured by either public insurance, Medicaid, or private insurance. You may need some additional numbers to put that finding in context. There are approximately 75,000 deliveries a year in Massachusetts. Of those, approximately 55,000 are women who have some sort of private insurance; that is about 70 percent. About 14,000 are Medicaid; that is about 19 percent. And then there were a remaining 6,000 women (8 percent) who were self-pay, who had no coverage at the time of delivery.

In addition, we found that health insurance policies were extremely uneven in their coverage of prenatal care services and often excluded maternity benefits.

In its recommendations, then, the task force attempted to address these particular gaps. It recommended that private insurance be mandated in Massachusetts to cover maternity benefits, and in fact, the Insurance Commission has enacted regulations to do so. It recommended increased Medicaid enrollments and expanded Medicaid eligibility, although in fact, Medicaid eligibility in Massachusetts is more liberal than in many other States.

And finally, the task force recommended that the State undertake a payor-of-last-resort program so that no woman would find herself uninsured for maternity benefits.

It is particularly on this latter program entitled "Healthy Start" that I want to focus the remainder of my comments.

In putting together the Massachusetts infant mortality initiative, there were several components that were funded with support from our legislature and the Governor. First, we undertook the promotion of public and private coalitions at a local level to analyze the problem of infant mortality and recommend solutions that were particularly appropriate to those communities.

Second, we are undertaking a modest media and outreach campaign to get information to women not only about healthy practices during pregnancy, but also about the availability of new funding under the Healthy Start Program, to give them access to care.

Third, a committee representing professional organizations and health care providers is working on the content of prenatal care and the standards of prenatal care, to make that care that we are now improving access to the best possible in terms of improving the outcomes.

And finally, we have undertaken a payor-of-last-resort program called the Healthy Start Program, that was begun in December of 1985. It pays for all medical expenses related to pregnancy and delivery as well as one post partum visit. To be eligible, a woman must reside in Massachusetts, be uninsured, be ineligible for Medicaid, and have an income below 185 percent of the Federal poverty level. To enroll, a woman can simply call a toll-free number—800-531-BABY.

More than 4,000 women have enrolled in the first 6 months of the program's operation. Healthy Start intake workers report that many are from low-income families with one or two wage earners and incomes above the Medicaid eligibility limit. Enrollment data indicate that the program has been successful in reaching the targeted population: 30 percent of Healthy Start women are from racial and ethnic minority groups compared to 15 percent of all pregnant women in Massachusetts; 20 and 21 percent are non-high school graduates and teenagers, respectively, compared to 8 and 9 percent of the total population of pregnant women in the State.

It should also be recognized that these new infant mortality initiatives are built upon a solid foundation of State maternal and child health title V programs, including 22 maternal and infant care projects that provide support to community-based prenatal care programs; a WIC program that reaches 63,000 women, infants, and children with both Federal WIC funds and a supplementary State appropriation; specialized programs for pregnant and parenting teens; a network of neonatal intensive care units, and community-based high-risk infant and family support programs that reach out to about 1,500 families.

In closing, I just want to comment that I am privileged to represent the staff of public agencies before this committee, both our commissioner of public health and the staffs of both the State title V agency and the State Medicaid agency that worked on the development of the Healthy Start Program. We wish to point out from our experience in Massachusetts that efforts to improve maternal and child health will require close collaboration between a strong State maternal and child health agency capable of analyzing, planning, operating, and evaluating program efforts and a strong State Medicaid Program committed to the operation of a humane and efficient medical payment program.

Further efforts at the Federal level to strengthen the links between title V and title XIX agencies will promote better maternal and child health.

Thank you.

The CHAIRMAN. Thank you so much, Dr. Guyer.

[The prepared statement of Dr. Guyer follows:]

TESTIMONY PRESENTED TO

U.S. SENATE COMMITTEE ON
LABOR AND HUMAN RESOURCES

PRESENTED BY:

BERNARD GUYER, M.D., M.P.H., DIRECTOR
DIVISION OF FAMILY HEALTH SERVICES

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
150 TREMONT STREET, BOSTON, MASSACHUSETTS 02111

July 16, 1986

Senator Hatch, Senator Kennedy, members of the Committee, I am Dr. Bernard Guyer, Director of the Division of Family Health Services in the Massachusetts Department of Public Health, the state Title V - Maternal and Child Health agency. Thank you for the opportunity to testify on the importance of assuring adequate prenatal care in efforts to prevent low birthweight and reduce infant mortality. To aid in your deliberations, I would like to:

1. Review the status of infant health in Massachusetts
2. Present the findings and recommendations of the Department of Public Health's Committee on the Prevention of Low Birthweight and Infant Mortality
3. Update you on Massaschusetts' initiatives to reduce infant mortality, including the Healthy Start Program.
4. Comment briefly on two pieces of proposed legislation, the "Medicaid Maternal and Infant Health Care Enhancement Act of 1986" and the "Children's Health Care Act of 1986", focusing particularly on the Title V provisions.

I. INFANT HEALTH IN MASSACHUSETTS

Massachusetts is extremely fortunate to have a healthy population and generally good indicators of maternal and infant health. In 1983 for example, we ranked eighth among the states for the best infant mortality rate (IMR) with 9.1 infant deaths per 1,000 live births. Massachusetts IMR was the best among all major industrialized states and ranked only behind smaller rural states, such as New Hampshire, Vermont, Maine and Utah.

In terms of low birthweight, Massachusetts ranked 16th best, with an overall percentage of low birthweight of 5.9%. Finally, Massachusetts ranked second among the states in early prenatal care with 85.6% of all deliveries receiving care within the first trimester.

However, these overall indicators of good pregnancy outcome in Massachusetts obscure high risk populations and areas in the Commonwealth. For example, data collected on a national level by the Children's Defense Fund show that the IMR for non-whites in Massachusetts in 1983 was 14.1, nearly double the rate for whites. The low birthweight rate for non-white births was 10.1%, again nearly double the percentage for whites. And while 86.6% of white women received early prenatal care, only 76.1% of non-white women, and only 60.3% of non-white teenagers received early prenatal care.

We are also fortunate in Massachusetts to have an excellent system of health care for women and children, funded, in part, through the Title V - Maternal and Child Health Services (MCH) Block Grant and State MCH appropriations. A network of 60 Community Health Centers provides access to primary obstetric and pediatric services to low-income women and children. We have a regionalized system of maternal and infant care which refers the most high risk women and sick neonates into 4 perinatal and 3 free-standing neonatal intensive care units in Massachusetts' excellent teaching hospitals. With these resources, Massachusetts could have one of the best infant mortality rates in the world, equaling that of Sweden or any other Scandinavian country, if we could improve birth outcomes, particularly by preventing low birthweight, among our highest risk populations - women who are low income, minority, and young.

II. STRATEGIES FOR IMPROVING THE HEALTH OF MASSACHUSETTS INFANTS - REPORT OF THE TASK FORCE ON PREVENTION OF LOW BIRTHWEIGHT AND INFANT MORTALITY.

At the Department of Public Health, we were extremely concerned when it was recognized that the infant mortality rate increased to 10.1 infant deaths per 1,000 live births in 1982 from 9.6 in 1981. This was the first increase in nine years and the largest in seventeen years. This increase prompted Massachusetts Public Health Commissioner Dr. Bailus Walker, Jr., to appoint a 19 member Task Force on the Prevention of Low Birthweight and Infant Mortality, chaired by Dr. Julius Richmond, Professor of Health Policy Research and Education at Harvard University and former U.S. Surgeon General.

The Task Force found gaps in rates of low birthweight and infant mortality among vulnerable populations in the state, as well as gaps in resources and services available to pregnant women, infants, and their families across the state. It concluded that there are unequal opportunities for infants to grow up healthy in the Commonwealth, and that these gaps must be closed if Massachusetts is to maintain and further its progress in preventing avoidable infant death and disability. The Task Force called for maximizing the opportunity for every infant born in the Commonwealth to enjoy a healthy development. The specific findings and recommendations of the Task Force can be summarized as follows:*

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* A copy of Closing the Gaps; Strategies for Improving the Health of Massachusetts Infants, May 1985 is appended to this testimony.

TASK FORCE FINDINGS: WHERE ARE THE GAPS?

1. GAPS IN RATES OF LOW BIRTHWEIGHT, NEONATAL AND INFANT DEATHS

Infant death and disability occur across the state in every racial, ethnic, and age group, but gaps between groups can be identified. These can be characterized:

- By racial and ethnic groups: Black rates were twice those found for whites; Hispanic rates were elevated.
- By geographical area: Springfield, Holyoke, and Boston, for example, have consistently exceeded state rates.
- By income level: The poor are at particular risk. 13% white children live in poverty; 39% black children; and 53% Hispanic children.
- By age: Mothers under 18 years old have outcomes that are generally poorer than older women.

2. GAPS IN ACCESS TO THE HEALTH CARE SYSTEM

One of the basic prerequisites to promoting infant health is the provision of health care to mothers and their infants before, during, between, and after pregnancies. Although these services are widely available in Massachusetts, barriers to obtaining them were identified.

- Utilization of prenatal care has declined in recent years. 85% and now registered in the first trimester.
- Affordability of care: In 1982, 6000 women were uninsured by Medicaid or private insurers.
- Health insurance policies excluded coverage for maternity services.
- Other barriers exist including: transportation, cultural practices, language.

3. GAPS IN COMPONENTS OF THE HEALTH CARE SYSTEM

Prenatal care must be comprehensive, addressing the interrelated factors associated with low birthwight and infant mortality. These include poor nutrition, smoking, alcohol and drug use, adequate spacing between pregnancies, stress, infection, and premature labor. In addition:

- Private obstetricians may not provide adequate access or comprehensiveness of care.
- Community health centers need support to maintain comprehensive services.
- Categorical programs (WIC, Family Planning) should be available for all eligible individuals and linked with other components

4. GAPS IN INFORMATION

While data collected and analyzed by the state provides a solid basis for program planning and policy development, some gaps were noted.

- Vital statistics should be available for specific important groups - especially Hispanics.
- Timely information must be available on local and regional populations.
- Research on barriers to care is needed.

TASK FORCE RECOMMENDATIONS: HOW CAN WE CLOSE THE GAPS?

The Task Force's recommendations fell within five broad strategy areas.

1. TARGET STRATEGIES TO SPECIFIC HIGH-RISK GROUPS AND AREAS

- Strengthen existing regional planning.
- Promote local and regional coalitions to plan and implement initiatives.
- The state MCH/Title V agency should provide technical assistance to these efforts.

2. MATERNITY AND INFANT HEALTH CARE MUST BE AFFORDABLE FOR ALL

- Mandate private insurance coverage of maternity benefits.
- Increase Medicaid enrollment.
- Expand Medicaid eligibility.
- Establish maternity payor of last resort program (Healthy Start).

3. COMPREHENSIVE MATERNITY AND INFANT CARE SERVICES MUST BE AVAILABLE TO ALL

- Ensure availability of physicians to serve Medicaid women.
- Expand use of mid-level professionals, i.e. nurse midwives.
- Promote culturally appropriate care.
- Expand public health prenatal programs in critically underserved areas - MIC projects funded through the Title V/MCH block grant.
- Expand WIC, family planning, and infant follow-up.
- Implement standards for comprehensive prenatal care.

4. INFORM WOMEN ABOUT HEALTHY PRACTICES AND ABOUT THE AVAILABLILITY OF SERVICES

- Begin a statewide media campaign.
- Community outreach should be part of all programs.

5. STRENGTHEN ONGOING MONITORING OF MATERNAL AND INFANT HEALTH STATUS AND NEEDS

- Improve statewide data collection.
- Disseminate timely data and reports.
- Review infant deaths and regionalized perinatal system.

III. THE MASSACHUSETTS INFANT MORTALITY INITIATIVE INCLUDING THE HEALTHY START PROGRAM

With the leadership and support of the Governor and the Legislature, the Department has embarked on an Infant Mortality Initiative, funded in FY 1986 at $6.7 million. The major components of initiative include:

- The promotion of public/private coalitions at the local and/or regional levels to address the needs and problems of communities at high risk of low birthweight, infant mortality, teen births and inadequate or no prenatal care. The coalitions will develop strategies to ensure access to comprehensive prenatal and infant care services for these high risk groups.
- A media and outreach campaign which will provide information on factors promoting healthy birth outcomes, stressing the importance of prenatal care and how such care can be obtained and paid for.

- A committee of representatives from professional organizations will develop comprehensive prenatal care, maternity and neonatal intensive care standards for statewide implementation. These standards will emphasize services and interventions to prevent low birthweight, including nutritional, psychosocial, educational and clinical interventions.
- A maternity payor-of-last-resort programs, Healthy Start, was begun in December 1985. It pays for all medical expenses related to pregnancy and delivery, as well as one postpartum visit. To be eligible, women must reside in Massachusetts, be uninsured, be ineligible for Medicaid, and have an income below 185 percent of the federal poverty level (for a married woman with one child, joint annual income cannot exceed $16,872). To enroll, women can call toll-free 800-531-BABY.

More than 4,000 women had enrolled as of the first six months of the program's operation. Healthy Start intake workers report that many are from low-income families with one or two wage-earners and incomes above the Medicaid eligibility limit ($5,964 annually for a family of three). Enrollment data indicate that the program has been successful in reaching the targeted population: 30% of Healthy Start women are from racial/ethnic minorities compared to 15% of all pregnant women in Massachusetts; 20% and 21% of Healthy Start women are non-high school graduates and teenagers, respectively, compared to 8% and 9% of the total population of pregnant women.

Healthy Start's coverage extends to teenagers - a group whose needs for prenatal care coverage have often been excluded by both Medicaid and private insurers. Recent changes in state law and insurance regulations require all private insurers to provide maternity benefits, including coverage for minor dependents, on the same basis as benefits for other conditions. Thus, in the future, teenagers will likely be less reliant on Healthy Start for financial assistance.

Health care providers invited to join Healthy Start are still in the process of registering. Obstetricians, family practitioners, community health centers, and hospitals that offer obstetrical care are forming a network of providers available to participants. Where providers do not offer a comprehensive range of services, such as nutrition counseling, social services, or health education, the Department of Public Health will attempt to arrange for these services through Healthy Start case managers located in the Department's four regional offices and in Boston. Regional staff will also assist providers by ensuring that women and infants are referred as necessary to other public health programs, such as the Women, Infants, and Children (WIC) nutrition program, or one of the early intervention programs.

In addition to the new state initiatives, the Department was successful in competing for a federal grant for an "Improved Prenatal Care Utilization and Birth Outcome Project." The grant of $218,000 per year from the federal Division of Maternal and Child Health will fund surveys of postpartum women and health care providers to identify factors that influence utilization of prenatal care and development of innovative service models. This grant represents an important aspect of federal/state collaboration.

It should be recognized that these new infant mortality initiatives are built upon a solid foundation of state MCH/Title V programs including:

- 22 Maternal and Infant Care (MIC) projects that provide prenatal sources to 4500 women.
- The Special Supplemental Food Program for Women, Infants, and Children (WIC) which reach 63,000 participants through use of Federal WIC and supplemental state funds.
- Specialized pregnant and parenting adolescent programs serving 1500 adolescents and reaching additional young women and men with education and counselling.
- A network of Neonatal Intensive Care Units which care for 6500 infants, in part with support from MCH.
- Community-based high-risk infant and family support programs that reach 1500 families.

IV. PROPOSED AMENDMENTS TO MEDICAID AND TITLE V.

We wish to comment briefly on the two pieces of proposed legislation being considered by the committee - the "Medicaid Maternal and Infant Health Care Enhancement Act of 1986" and the "Children's Health Care Act of 1986". In particular, we wish to focus our comments on the Title V provisions of these bills.

The "Children's Health Care Act of 1986" would add the state option to extend Medicaid eligibility to poor children and their families even if not categorically eligible provided that they meet certain resource tests. The proposed legislation promotes systems of referral, strengthens standards of pediatric care in EPSDT, establishes uniform reporting, and promotes case management for chronically ill children. All of these components will strengthen state Medicaid programs. In addition, the legislation proposes authorizing $10 million for each of three fiscal years, for demonstration projects to test the effectiveness of coordinated, integrated case management services in Title V programs for children with special health care needs. We enthusiastically support such projects and would suggest, from our experience in Massachusetts, that Congress consider legislation promoting the role of Title V agencies as case managers for children served under Medicaid.

The "Medicaid Maternal and Infant Health Care Enhancement Act of 1986" extends the amount, duration and scope of services to be provided to poor pregnant women with a particular focus on high-risk pregnancies.

In addition, this legislation specifies information and reports to be required from state MCH/Title V programs nationwide. Such requirements will strengthen needs assessment and accountability in Title V programs, and most of the data elements should be available to state MCH agencies. Generally, we would support these provisions but would add two suggestions. First, a mechanism for adding and modifying required data should be incorporated so that legislation is not required each time some new data element is considered for inclusion. Second, the role of the federal MCH office could be specified in providing technical assistance to the states on the development of data systems, and more importantly, the analysis and reporting of the data provided.

In closing, we wish to point out from our Massachusetts experience, that efforts to improve maternal and child health will require close collaboration between a strong state MCH/Title V agency capable of analyzing, planning, operating, and evaluating program efforts and a strong state Medicaid program committed to the operation of a humane and efficient medical payment program. Further efforts at the federal level to strengthen the links between Title V and Title XIX agencies will promote better Maternal and Child Health.

The CHAIRMAN. We will turn to you, Ms. Johnson, and take your testimony at this time.

Ms. JOHNSON. Mr. Chairman and members of the committee, my name is Kay Johnson, and I work in the health division of the Children's Defense Fund.

The Children's Defense Fund appreciates this opportunity to submit testimony on the subject of child health, and I would like to summarize briefly for you my remarks that I have submitted for the record.

The CHAIRMAN. Without objection, we will put your complete remarks in the record. We do appreciate your summarizing and trying to limit it to 5 minutes.

Thank you.

Ms. JOHNSON. I would be happy to.

For the past dozen years, the Children's Defense Fund has placed particular emphasis on the problem of poor children's lack of access to health care. In a nation such as ours, whose health care system is financed chiefly through public or private insurance, low-income children have traditionally faced substantial barriers to basic health care because they are disproportionately uninsured, and their families are unable to purchase necessary services themselves.

Moreover, there is substantial evidence that in recent years, poor children have increasingly lost both public and private health insurance coverage. At the same time, cost containment efforts in many parts of the country have reduced the amount of available charity care for low-income and uninsured persons in general, and for children in particular.

Thus, it is extremely timely for the Labor and Human Resources Committee to review how children's access to health care can be improved.

The childhood poverty statistics indicate that the Nation has been experiencing growth in, and a widening and deepening of, childhood poverty. By 1984, more than one-fifth of America's 62 million children under age 18 lived in poverty; nearly one out of every two black children, two out of every five Hispanic children, and one out of every six white children lived in poverty in that year.

The problem of uninsuredness among children also appears to be growing. As a result of reductions in coverage under employer-based health insurance plans and major reductions in Federal and State public insurance programs for low— income children, fewer children today have insurance coverage.

Estimates of uninsuredness today translate into numbers that mean of the approximately 61 million children under age 18 living in the United States, anywhere between 4.8 million and 10.8 million are without health insurance.

Children are especially likely to be uninsured as a group. However, poor children face particular problems. One in three poor children is uninsured for all or part of the year.

Our public insurance safety net is so tattered that current service levels allow programs such as Medicaid to serve millions fewer children now than in the mid Seventies. Between 1976 and 1985, the percentage of low-income persons eligible for Medicaid declined from 65 to 46 percent because of Federal budget reductions and States' failure to adjust Medicaid eligibility standards to keep pace with inflation.

The shortfalls in public programs serving children make attention to the private insurance system of increasing importance. In fact, our employer-based private health insurance system has failed to reach many children.

Poor and near-poor children with working parents remain uninsured as a result of four basic barriers. These include: employers that offer no health insurance; employers offering dependent coverage, but at an unaffordable cost; employers offering no dependent coverage; and employer plans that do not furnish appropriate benefits, such as no coverage for primary or well-child care services.

Childhood poverty as broad and as deep as that found in America today comes with a constellation of health risks. Furthermore, the health risks for all children have changed. As the profile of the American family and its lifestyle have changed, child health problems such as emotional—behavioral difficulties have emerged. As our medical technology has enabled us to increase child survival, more children live longer with the challenges of chronic illness and disabilities.

The evidence today suggests that children's health risks are increasing, with poor children continuing to suffer significantly lower health status than their non-poor counterparts; that poor children under-use health care in relation to their increased need; and that health insurance coverage is directly tied to utilization of health services.

The current gaps in medical coverage among children are costly in both human and fiscal terms. Yet maternity and pediatric services are not only effective they have been shown to be a remarkably cost-effective type of health care investment. Our sophisticated medical technology can offer preventive and remedial care for most child health problems. We understand how to keep most children healthy. We know that every child needs health care and that good medical care begins before a child's birth, with comprehensive prenatal care; it continues throughout childhood, with care for a child's preventive, acute, and chronic health care needs.

No child, whether the need is for immunization, treatment for a strep throat, dental care, hospitalization, medicines, or eyeglasses, should go without health care because a family cannot afford it.

The issue of medical indigency is not only an extremely serious one for the poor, but is also a substantial threat to the health care system that cares for the poor. Many public and community clinics and institutions face serious financial stress becuase of the combined effects of the large medically indigent population they treat and shortfalls among various public and private payors for their uninsured patients.

There are two basic approaches to dealing with the problem, and neither is exclusive. First, we need to improve public and private health insurance programs in order to generate a health care financing system that insures individuals for basic services. In the case of pregnant women and children, insurance reforms may be particularly modest in comparison to the long-term costs associated with failing to make such reforms.

Second, direct subsidies to public and community institutions providing a large volume of care for the uninsured are needed in order to promote targeted improvements and services.

In 1981, the Select Panel for the Promotion of Child Health in its report, "Better Health for Our Children: A National Strategy", examined our Nation's health policies in relation to children. The Select Panel found that gaps in eligibility for health financing and service programs were to a large extent the cause of inadequate access to care. As described above, these gaps have widened in the first half of this decade.

Medical indigency and the consequent limitations on access to care have grown to crisis proportions among our children. The Nation can no longer afford the human and fiscal costs of such neglect. We must begin now to fashion remedies to the problem of medical indigency among our most vulnerable populations.

The Chairman. Well, thank you so much. That was excellent testimony.

[The prepared statement of Ms. Johnson follows:]

Testimony
# of the
Children's Defense Fund
before the
Senate Committee on Labor and Human Resources
Regarding Barriers to Health Care: Children's Health

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Mr. Chairman and Members of the Committee

The Children's Defense Fund appreciates the opportunity to submit testimony on the subject of child health.

CDF is a national public charity that provides long range and systematic advocacy on behalf of poor children. We concentrate our efforts on a number of key issues including health care, child welfare, education, child development and child care, adolescent pregnancy prevention, and youth employment. CDF's work includes extensive research on these issues, as well as federal legislative and administrative advocacy, advocacy at the state and local levels, and technical assistance to public agencies, legislatures and policymakers in nearly all states.

For the past dozen years, CDF has placed particular emphasis on the problem of poor children's lack of access to health care. In a nation such as ours, whose health care system is financed chiefly through public or private insurance, low-income children have traditionally faced substantial barriers to basic health care because they are disproportionately uninsured and their families are unable to purchase necessary services themselves. Moreover, there is substantial evidence that in recent years poor children have increasingly lost both public and private health insurance coverage. At the same time, containment efforts in many parts of the country have reduced the amount of available charity care for low-income and uninsured persons in general and children in particular. Thus, it is extremely timely for the Labor and Human Resources Committee to review how children's access to health care can be improved.

In order to appreciate the barriers to health care services which exist for children, we must answer the following questions:

- What is the extent of poverty and medical indigency among children?
- What is the health status of children and is their current utilization of services commensurate with their need?
- What are the sources of health care for medically indigent children?
- What can be done to improve the health of children?

1. WHAT IS THE EXTENT OF POVERTY AND MEDICAL INDIGENCY AMONG CHILDREN?

Childhood poverty statistics indicate that the nation has been experiencing not merely growth in, but also a widening and deepening of, childhood poverty. Between 1979 and 1982, childhood poverty grew by one-third -- the greatest rate of increase since poverty statistics were first collected.[1] By 1984, more than one-fifth of America's 62 million children under age 18 lived in poverty.[2] Nearly one out of every two black children, two out of every five hispanic children, and one out of every six white children lived in poverty that year.

One indication of how deeply ingrained in American society childhood poverty is becoming is that of the more than 3 million children who fell into poverty between 1979 and 1982, the recovery which began in 1983 had, by 1984, lifted only 210,000 children out of poverty.[3] The 1984 childhood poverty rate was still greater than at any time during the 1960s. At the rate of improvement that took place between 1983 and 1984, it will take an additional 30 years for the nation to simply return to the childhood poverty rates it experienced in 1979.

Another indication of the growing seriousness of childhood poverty is that it is the youngest children -- those who have the most to gain from a good start in life -- who are the poorest. Poverty most widely affects the nation's youngest, most vulnerable children. By 1984, while one out of five children was poor, nearly one out of every four children under age six was poor.[4] Our youngest children were more likely to be poor than any other group of children. Indeed they were more likely to be poor than any other age group of Americans.

The problem of uninsuredness among children also appears to be growing. As a result of reductions in coverage under employer-based health insurance plans and major reductions in federal and state public insurance programs for low-income children, fewer children today have health insurance coverage. According to one recent study, while the number of children under age 18 declined slightly between 1979 and 1982, the number of uninsured children actually increased by 700,000.[5]

Depending on the particular study, anywhere from 7.9 percent in 1980 to 17.9 percent in 1982 of all children under age 18 had no health insurance, public or private.[6] Translated into today's numbers, these figures mean that, of the approximately 61 million children under age 18 living in the United States, anywhere from 4.8 million to 10.8 million are without health insurance.

Children are especially likely to be uninsured as a group. However, poor children face particular problems. One in three poor children is uninsured for all or part of the year. Poor children are three times more likely than non-poor children to be insured for only a portion of a year or not at all.[7]

Our public insurance "safety net" is so tattered that current service levels allow programs such as Medicaid to serve millions fewer children now than in the mid 1970s.[8] Between 1976 and 1985, the percentage of low-income persons eligible for Medicaid declined from 65 to 46 percent because of federal budget reductions and states' failure to adjust Medicaid eligibility standards to keep pace with inflation.[9]

The shortfalls in public programs make the issue of how well children are served by the private insurance system of increasing importance. In fact, our employer-based private health insurance system has failed to reach many children.

There is a serious and growing gap between parents' employment status and children's insurance status. In 1984, 86 percent of all children had at least one parent currently employed.[10] In contrast, 1980 data from the National Medical Care Utilization and Expenditure Survey (NMCUES) indicate that even before recent reductions in employer-based health insurance coverage, only 77 percent of all children had private insurance and only 65 percent were privately insured for a full year.[11] Indeed, it has been estimated that more than 27 percent of all children who are uninsured live with an insured parent.[12]

This discrepancy is even more startling among poor children. Even though nearly two-thirds of poor children live in employed families, only 34 percent had any private health insurance in 1980, and only 16 percent of all poor children under 18 were insured for the full year.[13]

Poor and near-poor children with working parents remain uninsured as a result of four basic barriers. These barriers include: a) employers that offer no health insurance; b) employers that offer coverage for employees only, thereby excluding dependent coverage even at the employee's cost; c) employers offering dependent coverage but at an unaffordable cost or with limits on family size and type; and d) employer plans that do not furnish appropriate benefits, such as no coverage of primary or well-child care. Moreover, access to coverage for children may be limited by plans requiring sizable deductibles and coinsurance payments. High deductibles and coinsurance can have a particularly chilling effect on children's utilization of preventive and primary care.

2. WHAT IS THE HEALTH STATUS OF CHILDREN AND IS THEIR CURRENT UTILIZATION OF SERVICES COMMENSURATE WITH THEIR NEED?

Childhood poverty as broad and as deep as that found in America today comes with a constellation of health risks. Among those risks are living conditions, including poor nutrition, inadequate housing and sanitation, and general family stress and hardship that threaten children's well-being. Poverty, and the social pressures and environmental hazards that accompany it, is associated with health problems in childhood.

Furthermore, the health risks to all children have changed. As the profile of the American family and its lifestyle have changed, child health problems such as emotional-behavioral difficulties have emerged.[15] As our medical technology has enabled us to increase child survival, more children live longer with the challenges of chronic illness or disabilities.[16]

The evidence today suggests that: a) children's health risks are increasing, with poor children continuing to suffer significantly lower health status than their non-poor counterparts; b) poor children underuse health care in relation to their increased need; and c) health insurance coverage is directly tied to utilization of health services.

a) Current Trends in Child Health Status

While the majority of the nation's children are in better health than ever before, some groups of children still face serious health risks as a result of limited access to health care services.

- Nearly one-third of all children under age 17 has never visited a dentist. Among black children this problem is even more serious.[17]
- Parents report that an estimated 40 percent of children ages 1-4 years are not immunized against measles, rubella, or polio. Non-white children are even less likely to be adequately immunized in their preschool years. The 1984 statistics point to a decline in preschool immunization since the mid-1970s.[18]
- Children ages 6-16 years have the lowest rate of visits to physicians of any age group,[19] with adolescents being least likely to make a medical visit.[20]
- Each year just under one million children and adolescents receive mental health or related services. Based on our estimates this means that two-thirds of seriously disturbed children and adolescents do not get the mental health services they need. Many more get inappropriate care.[21]

Moreover, our key indicators of child health point to a worsening in health status in recent years.

- The nation's rate of progress in overall infant mortality has slowed. The rate of improvement averaged approximately 3 percent per year between 1981 and 1983, the slowest rate of decline in 8 years and approximately half of the average annual decline during the 1970s.[22a]
- Between 1982 and 1983, postneonatal mortality rates (deaths among infants ages 28 days to one year) rose 3 percent nationwide.[22b] Deaths among older infants are of special concern because experts estimate that 80 percent of postneonatal mortality involves full-term, full-weight infants,[23] and that these deaths are a far greater reflection of the conditions under which children live and their access to adequate health services.[24]

- Between 1983 and 1984 there was a 69 percent increase in the number of cases of measles reported.[25] The CDC estimate that 75 percent of the cases among children 16 months to four years were preventable.[26]
- More children have been found to have chronic activity limiting conditions which affect both school and social performance.[27]

Among poor children especially, mortality statistics continue to remain high after the first year of life. Poor children are one-and-one-half to three times more likely to die in childhood.[28]

The consequences of illness also appear to be more severe for poor children.

- The evidence suggests that perinatal risks have a greater impact and more sequelae in poor children.[29]
- Poor children suffer a greater rate of complications from illness such as bacterial meningitis, diabetes, and asthma.[30]
- Poor children have 30 percent more restricted days of activity and lose 40 percent more days because of illness.[31]
- Chronic illnesses and handicaps continue to plague thousands of children and their families. These serious chronic conditions and handicaps are more prevalent among poor children than among their non-poor counterparts. Low-income children are much more likely to be unable to attend school, or to be limited in their ability to do so, because of a chronic condition than other children.[32]

b. Children's Utilization of Health Services in Relation to their Need

A number of studies have shown that when adjusted for health status, children, particularly poor and minority children, underuse health services.

- The 1980 National Medical Care Utilization and Expenditure Survey data reveal that 8 percent of children ages 0-2 will not see a physician at all during a year,[33] even though the American Academy of Pediatrics recommends no fewer than nine health exams in the first two years of life.[34] Near-poor and Hispanic infants and toddlers were twice as likely as all children to have no medical visits by age 2.[35]

- Researchers at the National Center for Health Statistics, reviewing 1978 Health Interview Survey (HIS) data, found that, adjusting for age and health status, the poor received substantially fewer services than the non-poor (3.5 - 4 visits per year vs. 5.2 visits per year).[21] Disparities in the use of preventive services were particularly striking; low-income women were less likely to receive prenatal care and young low-income children were less likely to be immunized.[36]

- An analysis of data from the 1981 HIS found that while healthy children appear to enjoy similar levels of physician services regardless of family income, there is a serious gap in service use for low-income children with reduced health status. This situation is particularly troublesome as it applies to children with activity limiting chronic conditions.[37]

- The Robert Wood Johnson Foundation, in its 1982 study, found that while the poor who actually obtained health services used more than the non-poor (5.9 physician visits vs 4.7 physician visits per year) the poor were twice as likely as the non-poor to be unable to obtain *any* service.[38]

- A study of special education students in five large metropolitan school systems found that, despite the identification of their special needs, 38 percent had no physician visit in the previous year. Lack of health insurance and low socio-economic status were both associated with reduced access to health care among this group.[39]

c. The Effects of Health Insurance Coverage on Health Care Utilization

When individuals' utilization of health services is considered in light of the effects of health insurance, it is evident that the uninsured use substantially fewer services than their insured counterparts:

- 1978 HIS data showed that the uninsured poor received one-third fewer physician visits than those with Medicaid and 16 percent fewer visits than other insured persons.[40]

- In its 1982 study, the Robert Wood Johnson Foundation found that one million families were refused care because they were unable to pay.[41]

For children, as for adults, the effects of having no health insurance are well documented:

- 1980 NMCUES data revealed that low-income uninsured children had a lower likelihood of, and a significantly lower average of, visits to physicians. When adjusted for health status uninsured children remain least likely to have any physician visits in a year.[42]

- One in three uninsured children had no physician visit in 1980, regardless of whether they had a regular source of care. For insured children, having a regular source of care significantly increased the likelihood of a visit.[43]

Thus, given poor children's lowered health status and their general underutilization of services relative to need, we should be particularly concerned about the situation of uninsured poor children who are without resources to obtain essential health services.

3. WHAT ARE THE SOURCES OF CARE FOR MEDICALLY INDIGENT CHILDREN

In an effort to more systematically measure the adequacy and scope of state maternal and child health services for medically indigent mothers and children, the CDF health division periodically conducts state-by-state surveys of public health programs. Based on the results of a 1984 survey of 23 states, we have been able to conclude that not a single state had the capacity to ensure access to appropriate maternity and pediatric services for women and children living below federal poverty levels.[44] While all of the survey states offer at least some preventive services (such as hearing tests, immunizations, or pap smears) in at least some counties, and while many states and localities have gone to extraordinary lengths to institute special programs for certain high-risk populations (such as pregnant women), no state is able to routinely provide or support the range of inpatient and outpatient services recommended by such professional organizations as the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the National Perinatal Association, the March of Dimes and other organizations.

Currently, a 50-state survey of a similar nature is being undertaken. A preliminary analysis yielded the following examples of the gap between mothers' and children's needs and states' and localities' capacity:

o In Connecticut the funds committed to filling gaps in maternal and child health services have failed to keep pace with the need. Despite a doubling in state appropriations for the delivery of prenatal care services to uninsured women in FY 86, the Maternity and Infant Protection Program was able to serve less than half of the state's estimated 7,000 poor and near-poor, uninsured pregnant women. The infants of many women in this group are able to receive primary care through the state's programs. However, outside of two communities' programs serving 3,000 children, poor and near-poor uninsured children must depend on city funds, private donors, and charity for coverage of their health care needs.

- Uninsured pregnant women and infants living in Illinois face serious health risks. In 1984, an estimated 60 percent of neonatal deaths (deaths to infants ages birth to 28 days) were reported among infants born to women receiving late or no prenatal care. One out of every five pregnant women in Chicago in that year had no health insurance. Public health clinics are unable to meet the need for services. Over 10 percent of state residents live in areas served by the Public Health Department and only half live in areas with full services. Furthermore, even where clinics exist, many are reported to have waiting lists so long that they are sometimes forced to turn away patients.

4. WHAT CAN BE DONE TO IMPROVE HEALTH CARE COVERAGE AMONG CHILDREN

The current gaps in medical coverage among children are costly in both human and fiscal terms. Yet maternity and pediatric services are not only effective, they have been shown to be a remarkably cost-effective type of health care investment. Our highly sophisticated medical system can offer preventive or remedial care for most child health problems.

Early and continuous prenatal care (which includes regular medical exams, treatment, nutrition, and other services) can reduce the incidence of mortality and low birthweight in infants by more than 25 percent.[45] Low birthweight is the single greatest cause of infant death and leads to significantly greater risk of developing permanent handicapping conditions among surviving infants.[46] Children born to mothers who receive no prenatal care are three times more likely to die in their first year of life.[47]

- Michigan state officials reviewing cases of 9,752 infants who were born at low birthweight and 6000 babies who received care in newborn intensive care units, estimated that, with good prenatal care, at a minimum 25 percent (1500 infants) would not have required such services. The state then determined that, while the cost of providing prenatal care to all 14,000 uninsured women was $4.9 million, the cost of providing neonatal care to the 1500 infants was $30 million. Thus for every dollar spent by the state on prenatal care, it would save $6.12.[48]

- Officials at the Lea County, New Mexico, High Risk Perinatal care project found that women who received adequate prenatal care showed the following characteristics:

  8 percent low birthweight
  15 percent resulting in maternal complications

  Without adequate prenatal care, women showed the following outcomes:

  16 percent low birthweight
  30 percent resulting in maternal complications

  By spending $64,000 on maternity care, the low birthweight rate would be cut in half, and savings of $310,000. Thus, for every dollar spent on maternity care, researchers found five dollars in savings.[49]

- The Colorado health department found that only 54 percent of low-income women begin prenatal care in the first trimester of pregnancy, as opposed to 80 percent of non-poor women. By providing adequate prenatal care to poor women, the state anticipated that 343 premature births could have been prevented (based on a 12 percent prematurity birthrate among 8,675 live births in 1975).

  Based on a 1977 study, the state estimated that among low birthweight survivors, lifetime costs were $20,000 per child. Moreover, specialized education and institutional services were required for 4 percent of low birthweight babies (between 3 and 5.5 pounds) and for 25 percent of very low birthweight babies (weighing under 3 pounds). For each of the babies with special problems, the cost would be approximately $123,000/child.

Based on the estimated costs of prematurity, the health department concluded that, for each $1.00 spent on prenatal care, $9.00 would be saved. If all long-term costs were included, the cost/benefit ratio would escalate to $11.00 saved for every $1.00 spent.[50]

Early and regular health care for children after their birth also saves lives. It helps prevent unnecessary pain and suffering, and it can avert or minimize long-term health problems. Thus, it plays a key role in enabling children to grow into healthy, productive adults.

- Timely immunizations can prevent unnecessary disease with important implications for both the child and the community. Research indicates that every dollar spent on the Childhood Immunization Program saves $10 in medical costs.[51]
- Lead poisoning is an excellent example of the type of periodic monitoring essential to children's health. Lead screening has been determined to be highly cost-effective and is crucial to hundreds of thousands of preschool children at risk.[52]
- Health professionals examining children in medically underserved areas found that over 80 percent of the problems were previously undetected, and some were serious. However, 96 percent of those problems identified were resolved or could be properly managed with prompt intervention, averting long-term harm to the child.[53]
- Children who receive comprehensive pediatric health care through Medicaid's EPSDT program have been shown to have reduced health problems and, as a result, annual health care costs 10-15 percent lower than children who do not receive such care.[54]
- A study conducted by the American Academy of Pediatrics

> shows a decrease in annual costs for children receiving continuing care. Those receiving the least amount of care had annual costs of $638.23; those receiving the most care cost $378.47.[55]

We understand how to keep most children healthy. We know that every child needs health care. Good medical care begins before a child's birth with comprehensive prenatal care. It continues throughout childhood, with care for a child's preventive, acute, and chronic health care needs.

No child -- whether the need is for immunization, treatment for a strep throat, dental care, hospitalization, medicines, or eyeglasses -- should go without health care because a family cannot afford it. No pregnant woman should be denied prenatal care because she does not have enough money to pay for it.

RECOMMENDATIONS

The issue of medical indigency is not only an extremely serious one for the poor, but is also a substantial threat to the health care system that cares for the poor. Many public and community clinics and institutions treating the poor are under serious financial stress, chiefly because of the combined effects of the large medically indigent population they treat and shortfalls among various public and private payers for their insured patients. Moreover, as noted above in the discussion of cost-effectiveness literature, medical indigency ultimately represents an enormous long-term drain on federal, state and local resources.

There are two basic approaches to dealing with the problem. Neither is exclusive. First, we need to improve public and private health insurance programs in order to generate a health care financing system that insures individuals for basic services. In the case of pregnant women and children, insurance reforms may be particularly modest in comparison to the longterm costs associated with failing to make such reforms. Second, direct subsidies to public and community institutions providing a large volume of care for the uninsured are needed, in order to promote targeted improvements and services.

1. **A program must be established that permits poor and near-poor working families to acquire health insurance.**

For the millions of poor and near-poor workers who are either not offered any group health insurance through the workplace or else are not offered coverage for dependents, a program must be established that permits workers to purchase affordable and adequate coverage for themselves and their families. Two basic options exist for achieving this goal. Congress might expand public insurance programs such as Medicaid to include a program of subsidized insurance coverage on a sliding scale for persons who are not poor enough to automatically qualify for Medicaid coverage but who lack insurance for themselves or their families and are unable to purchase it through their employer.

Alternatively, Congress might consider amending the federal tax laws to promote affordable private insurance coverage.

Employers might be given credits to underwrite premium cost for lower-income employees to ensure high quality plans. Or, in the absence of employer insurance, worker might be given tax credits to be applied toward the purchase of family health insurance coverage. Or, as some states are now doing, Congress might consider imposing a federal surtax on employer-purchased health insurance premiums. This tax could then be pooled and dedicated toward subsidizing the purchase of private insurance by uninsured groups of workers and their families.

2. Support to institutions serving the uninsured must be balanced with individual support.

Even with more comprehensive insurance, there will continue to be a need to directly support institutions serving the uninsured. While such subsidies are crucial, we believe that they should not be allowed to become the central focus of the governments effort to grapple with the problem of medical indigency. First because the medically indigent, especially children, generally require services that are not appropriately or cost-effectively provided in an institutional setting. Second, a focus on uncompensated care through reforms such as "bad debt pools" may not ensure equity in access to health care services on the individual level.[56] Uncompensated care remedies that take the form of direct subsidies to institutions threaten to perpetuate fragmented and inappropriate patterns of care.

3. **The benefit improvements embodied in S.376 the Child Health Incentive Reform Plan (CHIRP) should be enacted and expanded.**

All government-subsidized health insurance coverage should meet minimum scope and content requirements. This is the aim of CHIRP. The nation invests so many billions of tax dollars in subsidizing employer-purchased health insurance that it is difficult, if not impossible, to justify not setting a modest but important floor on benefit coverage.

CHIRP would require coverage of basic pediatric preventive services such as comprehensive physicals, immunizations, vision and hearing testing, and laboratory procedures.

In addition to the benefit improvements contained in CHIRP, we recommend that all employer-purchased plans be required to offer the following services:

- pediatric dental coverage: over 95 percent of all children need dental care; indeed, dental problems represent the most common childhood health condition of all. yet few plans offer such coverage;
- vision and hearing care, including eyeglasses and hearing aids;
- follow-up diagnostic and treatment services for conditions disclosed during a child's periodic CHIRP health assessment.

Each year the federal government spends several hundred million dollars directly through the Medicaid program to ensure that these recommended ~~serives~~ services are provided to poor children eligible for Medicaid EPSDT benefits. The justification for this expenditure is the broad body of literature confirming the cost-effectiveness of continuous preventive health care coverage of children. Children with comprehensive health insurance coverage are more likely to have a regular source of care; and having a regular source of care has been identified with better use of preventive services, more family awareness of good health practices for children, and lower overall health costs per child. If minimum federal standards for pediatric health care can be justified under a direct insurance program such as Medicaid, they are equally as justifiable under private insurance programs subsidized by large federal tax expenditures.

4. **Assistance to children whose special health needs are often overlooked.**

A group of especially vulnerable children is the 3 million seriously emotionally disturbed children and adolescents in our nation, only one-third of whom are currently receiving any help. The multiple needs of these troubled youth were described in detail in CDF's 1982 report *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services*, by Dr. Jane Knitzer.[57] Certain groups of children are particularly unlikely to get appropriate mental health services when they need them: disturbed adolescents; disturbed children in out-of-home care under the custody of child welfare or juvenile justice agencies; disturbed children from poor and disorganized families that cannot meet the children's special needs; and disturbed children with mentally ill, alcoholic, or substance abusing parents. Too frequently these youth fall through the cracks of the various human service agencies and do not receive the help they need.

Children are the most frequent losers among the many groups of emotionally or mentally troubled Americans now competing for scarce mental health dollars. Cutbacks in funds under the Alcohol, Drug Abuse, and Mental Health Block Grant and the Title XX Social Services Block Grant have left states to shoulder the burden of meeting the complex needs of this population virtually alone.

Certainly the funding of the federal Child and Adolescent Service System Program (CASSP) since FY 84 has meant a signifant boost to states working to improve the coordination of service delivery systems for seriously emotionally disturbed children. Twenty-two states are now using CASSP funding to develop or expand state level leadership for child mental health programs and to provide a continuum of coordinated services to meet the multiple needs of these troubled youth. Such state and local level administrative activities are essential, but much more is needed. To ensure that appropriate services are provided to these children and their families, at home, if possible, or in the least restrictive setting appropriate to their needs, support for CASSP must be maintained and increased, the earmark in the mental health block grant for new services for the severely disturbed children and adolescents must be strengthened, and we must turn our attention to developing a comprehensive framework for better providing the resources necessary to meet the complex needs of this population.

Conclusion

In 1981 the Select Panel for the Promotion of Child Health in its report Better Health for Our Children: A National Strategy examined our nation's health policies in relation to children.[58] The Select Panel found that gaps in eligibility for health financing or service programs were, to a large extent, the cause of inadequate access to care. As described above, these gaps have widened in the first half of this decade. Medical indigency, and the consequent limitations on access to care, have grown to crisis proportions among our children. The nation can no longer afford the human and fiscal costs of such neglect. We must begin now to fashion remedies to the problem of medical indigency among our most vulnerable populations.

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The **Chairman**. Let me turn to you, Mrs. Thurmond.

The Southern Regional Task Force on Infant Mortality, formed by the Southern Governors' Association, recently released a study which shows the South has the highest infant mortality rates in the Nation, and it recommends various steps to improve Federal and State services.

Are you aware of any efforts in your State, South Carolina, which are underway to help expectant mothers?

Mrs. **Thurmond**. Mr. Chairman, I am particularly pleased you asked that question in that I would like to give you a personal perspective about South Carolina.

In South Carolina, we are learning, we are progressing, and we are turning ideas and constructive proposals into action. Until recently, South Carolina had the highest infant mortality rate in the United States. Ten years ago, the mortality rate in South Carolina was 21.3 deaths per 1,000. Four years ago, that was down to 16.1; and in 1984, it dropped to 14.7.

In fact, if I may brag a little, the rate in South Carolina is dropping faster than the national rate. But since South Carolina's infant mortality rate is still one of the highest in the Nation, we really have much progress to make.

As many of you know, a major factor associated with infant death is low birth weight—babies born weighing 5½ pounds or less are about 40 times more likely to die than infants of normal birth weight. If they do survive, low birth weight babies are more likely to suffer lifelong debilitating diseases, life-threatening complications or handicaps.

In South Carolina, thanks to the excellent efforts of our Governor, Richard Riley, the South Carolina legislature, and hundreds of volunteers associated with the Healthy Mothers, Healthy Babies Coalition, we have a variety of programs aimed at preventing low birth weight and premature birth. We are providing prenatal and perinatal care and services to more and more of our citizens.

South Carolina this year became the first State in the Nation to provide by law free prenatal care for women not supported by Medicaid or another third-party source of payment. We have funds to provide nutritional supplements to a greater number of women and infants in need than ever before.

Not only does the State pay hospital expenses for high-risk pregnancy if necessary, but it also provides postnatal care, counseling, education and genetic services.

Another program I would like to mention is our Resource Mothers Program. Mothers with cars receive minimum wages to befriend a teenager during her pregnancy. The Resource Mother helps the young mother throughout her pregnancy and keeps in touch during the child's first year. This is a very human and compassionate program. This bonding and sharing of knowledge and support improves the teenage mother's use of health services, something that is often neglected or nonexistent. Programs such as Resource Mothers are important, especially since births to mothers under 15 are tragically on the increase.

So we have a long way to go in South Carolina, but we are making terrific strides, and we are really putting forth every effort.

The Chairman. It sounds like it.

Dr. Guyer, I am impressed with your testimony here today and with what Massachusetts health officials are doing to reduce infant mortality, and of course, I think that needs to be commended.

There are a couple of things about your testimony that do puzzle me. For instance, we hear over and over that if government would just provide prenatal care, we could reduce infant mortality. I agree that prenatal care is cost-effective and ought to be available, but what disturbs me about your statement—and you can clear it up for me—is that in Massachusetts, prenatal care is widely available, according to your statement, but yet only 60 percent of the nonwhite families actually avail themselves of the services.

My question is, Why should we expand Government-financed prenatal care when, even though it is widely available, 40 percent of the women in that category, or the targeted women, are not taking advantage of it? Is there not enough prenatal care, or is it really that prenatal care is available, but it is not being used?

Dr. Guyer. Senator Hatch, in responding to your question, I would reemphasize that average data sometimes obscure important differences between populations.

There are a series of reasons why there are women who do not get prenatal care in Massachusetts. First of all, the distribution of the services and the distribution of the population in need are not always the same.

For example, In a community like Holyoke, with a large, poor Hispanic population we had absolutely no clinical service providing prenatal care. Holyoke, women got on a bus and went to Springfield, about an hour away, to get to the nearest public funded, prenatal care program.

So clearly, in that community, we needed to have access, represented by a new program, and part of this initiative has been to provide that kind of new program.

In other parts of the Commonwealth, we found services available but identified other barriers to women. For example, in the community of New Bedford, we found that 20 percent of women had no insurance coverage for maternity care.

While we have not done a specific study in New Bedford, we know that it is a community with a large Portuguese population, many of whom are self-employed fisherman, and therefore uninsured. Thus, although, there are New Bedford obstetricians willing to take uninsured low-income patients, many of these patients delayed their prenatal care because they would have had to come up with the money up front. Many of these women delay their prenatal care—so that they can afford then the hospital charges for the delivery.

These are just two examples. But I think one has to look carefully at the distribution of services and the distribution of populations, and then examine other kinds of barriers—financial cultural language, and so forth.

The Chairman. I am going to submit additional questions to you. I find your testimony intriguing, and I want to commend you for it.

Ms. Johnson, let me just ask you one question. Someone once said, "There are lies, and then there are statistics." And there are some disparities in statistics among those who deal with this area.

Let me just talk about some of the statistics you used. What I am finding seems to differ with those, so let me just raise that.

For example, you state that between 1982 and 1983, postnatal mortality rates rose by 3 percent. But when I looked it up in "Health: United States 1985" book that is out, I found that the death rate for children under 1 year of age actually fell by almost 5 percent, and between 1983 and 1984, it fell by another 3 percent. It also said that the rate of decline in infant mortality was only 3 percent between 1981 and 1983.

By our calculations, the rate of decline during those years from 11.9 to 11.2 is about twice that. In addition, the decline from 1983 to 1984 was also, according to the records, about 6 percent—or at least, the records we are looking at.

I am wondering if our problem is Federal policies or the statistics involved. I just wanted to raise that.

Ms. JOHNSON. I would be happy to clarify those issues. These data are representative of the National Center for Health Statistics data. My analysis comes from the National Center for Health Statistics data.

The CHAIRMAN. OK.

Ms. JOHNSON. We have continued in a decline in overall infant mortality. The Nation's progress has slowed somewhat. The 3 percent per year is the annual average, and so therefore yours would reflect over a 2-year decline, about twice as much. So 3 percent is the annual average for those years.

Our progress has slowed, although we continue to make progress, and of course, as reported in "Health 1985", we have the lowest ever recorded infant mortality rate. Although, as I mentioned, our progress has slowed in that area.

In terms of the area where we have had an actual rise, it is among those older infants—and those are again National Center for Health Statistics data. It is actually after the first month of life, after we have made our heroic efforts to save those babies through neonatal intensive care and have saved many of them, that we lose some of those low birthweight babies after their first month of life. Other babies, we lose through accidents, unintended infections–a lot of those deaths are as a result of pneumonia or poisoning or automobile fatalities. Some of them are as a result of SIDS.

Most of those deaths do involve babies who are born full weight, full-term, not the low birthweight babies who are more likely to die in that first month where we are likely to have an early failure.

The CHAIRMAN. OK, thank you.

I think I will turn to Senator Kennedy at this time.

Senator KENNEDY. Thank you, Mr. Chairman.

Mrs. Thurmond, we want to extend a warm, bipartisan support welcome to you here this morning and want to commend you for your interest and your activity in these areas. I think it is a very exemplary, constructive effort on your part, and we want to thank you very much for coming here.

I would be interested in what your own sense is about the failure of our society to give this whole issue the kind of priority which obviously you have given it. What is your own thinking, in talking with people, about why we are as a society not more concerned about this whole issue?

What is it about us that does not give this the kind of priority that we should? I think probably all of us grew up in situations where we emphasized and stressed the importance of children being our most important resource and the future of our country; those are common words that are used by those across the political spectrum, and yet we still have these kinds of problems which you have outlined very eloquently.

How do we reverse that, do you think?

Mrs. **Thurmond**. Senator Kennedy, first of all, I think that until relatively recent years, just the raising of public awareness that there was such a tremendous problem was not evident to the general public. It is a matter of communication and education. And through hearings such as this, certainly the networking that will be done will be tremendously beneficial to raising public awareness and to getting the necessary programs into action so that we can reduce the infant mortality rate across-the-board.

I think that is the bottom line, is that it is only through communication and education and raising public awareness that we can really get something done. And for that reason, we are all very indebted to you and the members of your committee for bringing this issue to the forefront. And certainly, as a Senator, you know the many, many priorities that you have for the economy, for the national security of our country, and for other very, very important issues. And certainly, this issue is extremely important, but it is one of many, many important issues, and so there is a limit to the national focus that can be put on any one issue.

Senator **Kennedy**. That is, a very good response and also very accurate, I think, and I certainly hope you will continue to probe us all on this type of priority. I think it is very helpful for the country and what we all care very much about.

I want to thank you very much for your involvement, and hope you will continue to let us know about what conclusions you reach and what ideas you might have that you find to be successful. We want to thank you very much.

Mrs. **Thurmond**. Thank you.

Senator **Kennedy**. Dr. Guyer, let me ask you what have we really learned, do you think, from the Massachusetts experience that would have general application to the rest of the country, or can we reach any conclusions based upon what we are doing up there that might be beneficial to the rest of the country?

Dr. **Guyer**. Well, to start with, I have often said we are rather fortunate in Massachusetts. That map on the wall behind you points out the areas of high infant mortality in the United States; Massachusetts is not highlighted. We have done well. We have a strong economy. We have a population that has high employment.

The important thing that we have done, though, is tried to focus in on that population that is not receiving all the benefits of our general good state of affairs.

It is a bit early for us to draw conclusions for the rest of the country. We have only a little bit more than 6 months of experience with the healthy start program.

Senator **Kennedy**. The numbers that you have got, do they exceed what you expected, or are they less than what you expected?

Dr. GUYER. We have more than we expected, in fact. The kinds of numbers that we used to estimate the response to healthy start came from estimates of insurance coverage at the time of delivery. Those numbers may be underestimates, or else the number of women who are uninsured at the time of delivery has actually increased from the years that we used to estimate the program size. We ~~are~~ not sure which. We are projecting even more women registering for this program next year and are trying to budget for that.

Senator KENNEDY. Just briefly, do you have any recommendations based upon your other experiences in this area that we could undertake here at the Federal level that could make some difference?

Dr. GUYER. Well, perhaps I could make one comment that relates to one of your bills, about the importance of reporting and data, and the questions that Senator Hatch raised.

I think over the past 6 years, there has been in general a decrease in the availability of Federal statistics and the emphasis of the Federal Government on requiring good data from States on using the resources of the National Center for Health Statistics and others to make sure that we have timely, accurate data in some of these areas so that we can make policy from them.

The attempts in the legislation to improve data from title V agencies, I think is important, and I think most State title V programs would support that and would like to see the Federal Government doing more to support our efforts in those areas.

Senator KENNEDY. Ms. Johnson, I think we made available to you this Children's Health Care Act of 1986 and the Medicaid Maternal and Health Care Enhancement Act of 1986. Could you make what comments you would like to about those in particular?

Ms. JOHNSON. I would say first of all that we support all of the efforts to improve Medicaid and particularly those which expand eligibility for poor pregnant women and children, which is one of the major intents of these child health bills.

Because both bills are relatively complex, I would like an opportunity to supply written comments for the record.

The CHAIRMAN. We will be happy to do that. We will keep the record open for you.

Ms. JOHNSON. Thank you.

[Additional comments of the Children's Defense Fund follow:]

Children's Defense Fund

122 C Street, N.W.
Washington, D.C. 20001

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Telephone (202) 628-8787

August 8, 1986

The Honorable Edward M. Kennedy
113 Senate Russell Office Building
Washington, DC 20510

Dear Senator Kennedy:

Thank you once again for allowing the Children's Defense Fund to testify before your Committee during its recent hearings on maternal and child health. Your contributions on this issue, particularly your recent efforts to ensure inclusion of accelerated Medicaid eligibility determination reforms for pregnant women in the Senate reconciliation bill, have been invaluable.

We have enclosed in-depth comments on "The Medicaid Maternal and Infant Health Care Enhancement Act of 1986." We believe that this legislation is tremendously important.

Sincerely,

Sara Rosenbaum
Director, Health Division

SR:sc

Additional testimony of the Children's Defense Fund for the Senate Committee on Labor and Human Resources: Comments on S.2649 and S. 2650

1) General comments:

We support all of your efforts to improve Medicaid, particularly those which expand eligibility for poor pregnant women and children.

2) Comments on S. 2650 the "Medicaid Maternal and Infant Health Care Enhancement Act of 1986":

Title I Medicaid

We recommend revision and simplification of Sec. '101, 102, and 103. We strongly support these sections' overall goal of assisting high risk women in becoming eligible for Medicaid and receiving all necessary medical care. However, systems that assign women to risk categories are likely to be both underinclusive and overinclusive. They may exclude women who do not exhibit typical risk factors early in pregnancy and include women who are not in need of certain medical or technological benefits.

Risk assessment tools, which define the factors that place a woman at high risk during pregnancy are constantly being refined. In fact, a number of states have developed extensive protocols for identifying high risk women or for weighting reimbursement rates to those providers who serve women determined to be at social or medical risk. These judgments should be based on the latest research about risk indicators and should remain flexible to allow for incorporation of new findings and understanding. By prohibiting all amount, duration and scope limitations, your bill will enable providers to tailor specialized or enriched prenatal care services to women who are determined to be in need of such care, and the risk assessment and treatment programs can more easily change as the level of professional knowledge evolves.

o Sec. 101: In order to ensure delivery of all comprehensive prenatal care, including both medical and support services, the bill should define a mandatory package of prenatal care services which includes the following required and optional services now recognized under federal law: inpatient hospital services; outpatient hospital services; laboratory and x-ray services; physicians services; nurse midwife services; clinic services, including rural health clinics; family planning services; dental services; prescribed drugs; and early and periodic screening, diagnosis, and treatment services. We recommend that such a package of maternity services be structured to mandate any service which may be currently considered optional for other groups of recipients.

o Sec. 102: This is an excellent and important provision. To most effectively reach women at risk, we recommend that the bill be amended to not only require provision of the package of prenatal services (as defined above) without regard to amount, scope, and duration limits but also to specify that coverage limitations may be based only on medical need.

Currently, more than a dozen states place limits on the number of physician visits or the number of hospital days for which they will reimburse a Medicaid provider. For example, several states allow only 12 clinic or physician visits per year. A woman experiencing a high risk pregnancy can easily use this number of visits just through the basic prenatal care she receives (The American College of Obstetrics and Gynecology schedule calls for 13), leaving no margin for visits for underlying medical conditions which may complicate the pregnancy. Similarly, at least four states place limits of 15 days or fewer for covered inpatient care, an amount that can easily be exceeded, even prior to delivery, by a pregnant woman at high risk of preterm delivery.

We therefore recommend that the language be changed slightly to read:

"(48) provide for making service covered under the plan and relating to pregnancy or to any other condition which may complicate pregnancy available to pregnant women eligible for medical assistance under the plan without limitation as to amount, duration, or scope _and based solely on medical necessity_".

o _Section 103_: The issue of accelerated eligiblity is an important and timely one. As the role of early prenatal care has emerged as the cornerstone of maternal and infant health, early enrollment and accelerated eligibility for Medicaid have become increasingly important. We believe, however, that your bill as drafted will only place undue pressure on states to process applications without ensuring that care is provided expeditiously. Hard-pressed welfare agencies may be inclined to deny applications in order to meet the 10 day rule, and women will be left without coverage. We therefore recommend that the bill be amended to include an accelerated eligibility program which provides immediate coverage to pregnant women during the eligibility determination period and provides them with assistance in filing applications. The following amendment was recently incorporated by the Senate Finance Committee into their FY 1987 Reconciliation package:

Accelerated Medicaid Eligibility for Pregnant Women

I. In the case of pregnant women, the agency may accelerate eligibility for medical assistance for ambulatory prenatal care services, but not soley for delivery-related services. Under such an accelerated program, the agency may furnish eligibility for a period not to exceed 45 days if:

a) the woman has begun maternity care with a qualified Medicaid provider that is described in subsection (e);

b) the provider, as described in subsections (a) and (e), determines that the woman's monthly family income does not exceed eligibility levels for medical assistance established by the state under Section 1902(a)(10)(A) or (C) of the Act; and

c) the provider notifies the agency within 5 working days of the woman's presumed eligibility under this Section.

d) The agency shall furnish providers participating in the accelerated eligibility program with applications for medical assistance and information on how to assist women in completing and filing such applications.

e) A qualified Medicaid provider who is eligible to participate in the accelerated eligibility program may include the following providers:

  i) Recipients of funding under Section 330 329 of the Public Health Service Act,
  ii) Recipients of grants under Title V of the Social Security Act,

iii) Participants in Section 17 of the Child Nutrition Act of 1966 or Section 4(a) of the Agriculture and Consumer Protection Act of 1973; or

iv) A provider described in Section 1905(a)(2)(A) or Section 1905(a)(2)(B), or Section 1905(a)(9).

f) Agencies may also utilize providers who participate in a state run perinatal program or other providers whom the state determines are capable of administering an accelerated eligibility program and of furnishing care and services that are of high quality. At its option, the agency may bar from the accelerated eligibility program any provider that is not accurately determining family income as required under subsection (b).

g) Eligibility, in addition to the accelerated eligibility period, shall continue for pregnant women who have applied for and been found eligible for medical assistance. Federal medical assistance for payments made on behalf of pregnant women during the accelerated eligibility period shall be at the same rate as that described under Sections 1905(b) and 1903(a)5, regardless of whether such women are ultimately determined to be eligible for medical assistance.

h) Section 1903(u)(1)(D) of such Act (42 U.S.C. 1396b(u)(1)(D)is amended by adding at the end thereof the following new clause:

"(v) In determining the amount of erroneous excess payments there shall not be included any error resulting from an accelerated eligibility determination made with respect to pregnant women as described in section ___ (whatever section of Title XIX, Medicaid, is amended by the above I and II.)"

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o Section 104(a)(2): We strongly support the inclusion of clinics as Medicaid providers. The evidence suggests that many low income families use public health and community clinics as a regular source of health care when they are available. We recommend therefore that the definition of "clinic" services contained in the bill be expanded to incoporate the full definition of clinic services found at 42 CFR Section 440.90.

This definition describes clinic services as "preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services provided to outpatients by a facility that is not part of a hospital but is organized to provide medical care to outpatients." Such a definition, unlike that contained in the current bill, would permit reimbursement for the activities of all clinic staff.

We would also amend Section 104 to permit charges to be counted by low income women as incurred bills under the Medically Needy program. Currently, low-income families receiving health services from Title V clinics are unable to "spend-down" to become eligible for a state's Medically Needy program because, since such services are furnished free of charge to the poor, they incur no expenses. This situation makes it particularly difficult for pregnant women receiving prenatal care in Title V clinics to become eligible for Medicaid. As a result, they have no way to acquire services not furnished by the clinic, such as hospital and pharmacy services.

Title II Maternal and Child Health Services Block Grant

o Sec. 201 We commend these efforts to increase reporting requirements for Title V Maternal and Child Health Agencies. Current reporting requirements produce data insufficient to track the progress and effectiveness of the program. In addition, however, we believe that the stated list of information is too detailed in its specifications of statistical information on maternity care and includes too little information on child health services, particularly services to children with special health care needs. We recommend broader language which would require states to prepare comprehensive program and demographic data which would be submitted to the Secretary on an annual basis.

3) **Comments on S. 2649 the "Children's Health Care Act of 1986"**
Title I Medicaid

o Sec. 101 (a) (1) (iii) (I) and (II): We strongly support the expansion of coverage to poor children one to six years and six to eighteen years living above state AFDC guidelines. These are the next groups targeted in the National Governor's Association initiative, and each group has a well documented need for improved access to health care services. Clearly, a healthy start in life begins with early and comprehensive prenatal care and appropriate health care throughout the first year of life, however, children's health care needs continue throughout childhood. Many serious conditions do not appear in the first year of life, and many illnesses which occur during childhood call for prompt treatment to avoid longterm, costly consequences.

We would amend the bill to provide that in determining eligibility of these children for coverage, states must use the resource standards and methodologies of the SSI program. The AFDC resources standard disallows many of the assets held by working poor families, making it impossible for families to both earn a living and secure Medicaid for their children. The SSI test, on the other hand, provides a more generous resource test for such groups as farm families and the self-employed.

o Sec. 101(a)(1)(iii)(III): This subclause includes caretaker relatives in AFDC and AFDC-UP families; however, it excludes two-parent working poor families. We recommend strongly the inclusion of the parents in all poor families in which coverage would be extended to children. The bill goes far in delinking AFDC and Medicaid eligibility for children, yet continues to isolate certain caretaker relatives as ineligible.

o Sec. 101(A)(2): This subsection on application of income standards uses the Title IV A income methodology. Yet use of the Title IV A methodology is in many ways contrary to the apparent intent of the bill: to allow more poor families, especially those who work, to become eligible for Medicaid. Under the Title IV A methodology, working poor families are extremely disadvantaged. An improved methodology would allow families to deduct their real child care expenses, their actual work-related expenses, and an ongoing income-disregard of at least $30 and one-third of earned income as an incentive to continue working. Each of these broader methodologies was in place prior to the 1981 OBRA changes in AFDC.

o Sec. 103(b): This subsection would require states' EPSDT programs to meet reasonable standards with regard to frequency of care. However, the bill does not address issues related to limitations on the amount, scope and duration of diagnostic and treatment services under a state plan.

o Sec. 104: Because definitions of chronic illness, developmental disability, handicaps, and special needs are variable, we recommend that this provision be broadened to make case management services to any child receiving medical assistance who has a medical or health condition requiring case management. The vagueness of definitions now in the bill leave open the door to exclusion of certain groups of children if they must be defined. For example, a standard list of chronic illnesses includes anywhere from 10 to 25 diagnoses and conditions and may not include such common long-term illnesses as asthma or cancer. Furthermore, because the EPSDT program already provides for case management for the child who has a condition disclosed by an EPSDT screen, a provision which includes all recipient children would in effect mean addition of only those children with previously disclosed conditions.

Ms. JOHNSON. I would also like to encourage consideration and continued support for pieces such as those embodied in S. 2333, and we hope you would urge your colleagues in the Finance Committee—11 of whom are cosponsors of this bill—to move as quickly as possible toward enactment of those pieces, so we can move on and make progress for the children in this area.

Senator KENNEDY. Well, I am very hopeful that on reconciliation, we will be able to achieve that. I think we can make a strong case that we can provide savings, and that it makes sense not only from a health point of view, but from a cost point of view. So we will continue to press that.

I would welcome what comments you would have on the other proposals, and we are strongly committed toward the goals which the pieces of legislation that have been introduced, and we are going to make a very significant effort to try and achieve those goals of those pieces of legislation. But we would welcome whatever suggestions you or any of the others—maybe Dr. Guyer will take a look at that, and I will ask Mrs. Thurmond maybe to take a look at it as well, about those particular pieces of legislation that deal with this subject matter. We would welcome whatever comments or suggestions you might have.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Kennedy.

We want to thank each of you for being here. You have been very helpful to the committee, and we will make all of your full statements a part of the record and keep the record open for any additional things you would like to submit to us.

Thanks so much. We appreciate having all of you here.

Our next panel will discuss the issues of uncompensated health care. Because of the changes in the way we pay for health care and the increased competition in the health care marketplace, we all agree that there are some gaps in the delivery of health care, specifically for individuals who are insured and uninsured.

Today's experts will share with us their views on this issue and hopefully share with us some ways of reducing these gaps.

First, I am very pleased to welcome Mr. Scott Parker, from my own home State of Utah. Scott, this is the first time that you will present testimony before the Senate Committee on Labor and Human Resources, and I really personally appreciate your being here with us today. You are wearing two hats—one as president of Intermountain Health Care in Utah, and one as chairman of the Board of the American Hospital Association. So I appreciate your taking the time to be with us and present us with your counsel.

The second witness will be Mr. Walter B. Maher, who is director of employee benefits and health services for the Chrysler Corp. Mr. Maher is also here representing the U.S. Chamber of Commerce.

Our third witness is Ms. Nancy Santilli, who is representing the Coalition on Health Insurance Availability. Ms. Santilli is also representing the Epilepsy Foundation.

We went to thank all of you for being here and welcome you to the committee. We look forward to taking your testimony, and we will start with you first, Mr. Parker.

We would like to limit you each to 5 minutes. We are running out of time, and we will put all statements in the record as though fully delivered.

Mr. Parker?

STATEMENT OF SCOTT PARKER, PRESIDENT, INTERMOUNTAIN HEALTH CARE, INC., SALT LAKE CITY, UT, AND CHAIRMAN OF THE BOARD, AMERICAN HOSPITAL ASSOCIATION; WALTER B. MAHER, DIRECTOR OF EMPLOYEE BENEFITS AND HEALTH SERVICES, CHRYSLER CORP., DETROIT, MI, AND CHAIRMAN, TASK FORCE ON RETIREE HEALTH CARE, U.S. CHAMBER OF COMMERCE, ACCOMPANIED BY JAMES A. KLEIN, MANAGER OF PENSION AND EMPLOYEE BENEFITS, U.S. CHAMBER OF COMMERCE; AND NANCY SANTILLI, ASSOCIATE DIRECTOR, COMPREHENSIVE EPILEPSY PROGRAM, UNIVERSITY OF VIRGINIA MEDICAL CENTER, CHARLOTTESVILLE, VA, AND MEMBER OF BOARD OF DIRECTORS, EPILEPSY FOUNDATION OF AMERICA

Mr. **Parker**. I will respond to that request and thank the committee for the opportunity of being with you.

The focus of my brief remarks this morning will be on health care for the poor, which is the No. 1 priority and concern of the American Hospital Association. And because it is our major concern, we are very pleased that it is your concern, as is evident by your discussion of the proposed bill to address this problem.

Last month I was invited to attend the Canadian Hospital Association, and in the course of those meetings I sat at lunch flanked by the chairman of the Board of the Canadian Hospital Association and the president-elect of the Canadian Medical Association. We naturally exchanged views about our two health care systems, and they explained to me with appropriate pride that the foundation piece of their system is financing of care for all Canadians, regardless of ability to pay.

I, of course, outlined the positive features of our system and our approach to financing health care, and I frankly wish that I had been able to state with some confidence that our Nation is committed to correcting a very serious flaw in our price-competitive system. The price-competitive system has many advantages that we are enjoying together now, but it has one serious flaw that both Senator Hatch, and you Senator Kennedy mentioned this morning, and that is that over 30 million people in this country have no insurance, and therefore they have a very difficult time finding access to health care.

That brings me then to comment specifically about the initiative that you are considering, the Access to Health Care Act of 1986.

We as a hospital association are supportive of the basic principles underlying this proposed legislation. I would like to explain why. Several of the suggested initiatives would make private health insurance available to individuals currently unable to obtain that insurance either because of their medical condition, which keeps them from being accepted by commercial insurance, or their employees do not have group coverage, and other employers do not expand existing group coverage after employees are no longer employed. That means these people have to face high insurance premiums for nongroup payments in the marketplace. And that is prohibitive, obviously, because there are 30 million people out there without it.

We are also supportive of the proposed legislation because it calls for incentives for individual States to take the initiative to deal more responsively with the indigent care requirements within their own States. We feel that it is essential that the costs of indigent care be spread broadly and equitably through the use of funding sources that ensure participation by all citizens.

We have serious concerns regarding one of the suggested penalties in the House version that would deny Medicare payments to hospitals in any State that might choose not to take such an initiative. We feel that the State which makes that decision should be penalized, and not the local hospitals or the Medicare patients.

We also support the legislative initiative directed toward extending employers' responsibilities to make health care insurance available for an extended period of time following layoffs. This would improve the continuity from one insurance plan to another that is so vital if we are to fill this gap for the uninsured. If it is felt that such requirements would be onerous for the very small business operator, perhaps hardship exemptions could be considered.

We support the initiative that would extend tax deductibility of health insurance premiums to those who are self-employed.

And finally, we applaud the proposed initiative that calls for funding demonstration grants for the States.

By the way, we also support the changes in the Medicaid coverage that were addressed in the previous hearing. We believe that is a sound and good investment, both socially and economically.

Now let me conclude my comments by reporting to you on the reality of the intensive price competition going on in this country—among hospitals and among all providers.

We feel the whip of that competitive environment, as we understand and support the advantages in terms of cost control. And we are committed as a hospital association and as member hospitals to continue to provide care to the needy, regardless of their ability to pay, and in spite of the increasing difficulty to do so.

Examples of hospitals abrogating these basic responsibilities are fortunately very rare, and they are never acceptable. As hospitals, we are actually providing more care for the poor and expanding the base from our own resources.

We look to you for your leadership and for your initiative in attacking one of the root causes of much of the indigency problem, and that is the lack of insurance coverage for many Americans.

The written testimony which we have submitted to you identifies other concerns and recommendations regarding the bill that we presented to you, with the thanks of the American Hospital Association for your leadership on this subject.

We urge your serious consideration of this initiative, because it is designed to resolve a very serious flaw in what otherwise could be called a superb national health care system.

Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Mr. Parker follows:]

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STATEMENT OF
SCOTT PARKER, PRESIDENT, INTERMOUNTAIN HEALTH CARE
ON BEHALF OF THE
AMERICAN HOSPITAL ASSOCIATION
BEFORE THE
COMMITTEE ON LABOR AND HUMAN RESOURCES
OF THE
UNITED STATES SENATE

July 16, 1986

INTRODUCTION

On behalf of the communities served by Intermountain Health Care and the 5,600 institutional members of the American Hospital Association, I am pleased to have this opportunity to testify before the Committee on Labor and Human Resources on several measures that have been proposed to address the issue of medical indigence. The past five years have witnessed tremendous changes in the financing and delivery of medical care. They have also seen the reemergence of medical indigence as a significant public policy issue. Twenty years after the enactment of Medicaid, more than 30 million Americans are without private health insurance and are not covered by public programs. And Medicaid itself is no longer the primary source of financing for Americans whose income falls below the federal poverty level. The initiatives before this committee are an important step in a renewed effort to find a lasting solution to the problem of medical indigence.

PERSONAL PERSPECTIVE

Recently, I had the opportunity to spend some time with the leadership of the Canadian Medical Association and the Canadian Hospital Association. In contrasting the accomplishments of our different systems of medical care, the Canadians emphasized their comprehensive coverage. No Canadian faces the possibility that medical care will exhaust their resources. In contrast, the greatest accomplishments of the American system are its flexibility and its increasing competitiveness and efficiency. Both of these are important achievements of which we can all be proud. But in our pursuit of increased competition, we cannot--and I am sure we will not--lose sight of the need to ensure access to needed medical care for all members of society.

There can no longer be much doubt that competition provides the most effective means of improving efficiency and stimulating innovation. The greatest challenge for the new, competitive health care system that we are forging is medical indigence. The traditional methods of financing care for the uninsured will be stressed beyond their capacity as competition continues to increase. There is no question that hospitals providing substantial amounts of care to the medically indigent are less able to compete than hospitals which by virtue of their location or mission provide smaller amounts of care to the medically indigent. Unless new sources and methods of financing care for the medically indigent can be found, these hospitals may be forced to close, jeopardizing the ability of many to obtain needed medical care.

It is important to realize that what is needed are primarily new methods of financing care for the medically indigent, and not increased total funding. New methods of financing and delivering care have, over the past three years, resulted in an enormous reduction in the rate of increase in hospital and medical care costs. The reduction in the rate of increase in total cost and private insurer expenditures has not been matched by a reduction in the rate of increase in uncompensated care cost. In fact between 1980 and 1984, revenues and costs associated with private payers increased by only 40 percent, while unsponsored care cost rose by more than 100 percent. What is needed is to invest some of these "savings" realized by private and public payers in stronger, more rational programs to ensure access to care for the medically indigent.

Over the years, but particularly in the past two years as an officer of the American Hospital Association, I have had the opportunity to meet with hospital managers from every part of the country. Every region of the country, and nearly every community, has its own history, problems, and ways of handling those problems. The problem of medical indigence varies from community to community and state to state, but in every state it is a major issue on the minds of hospital managers and public policymakers. In a state such as Utah, for example, we have a strong tradition of communities and community institutions providing for their less fortunate members. As a result, the problem of medical indigence is somewhat smaller in Utah than in other states. For example, in Utah uncompensated care accounts for 4.6 percent of total costs, slightly less than the national average of 6.1 percent, but considerably less than the comparable figures for Texas (12.6 percent); the District of Columbia, Mississippi or South Carolina (10.7 percent); or New Mexico (10.1 percent).

TOWARD AN ENDURING SOLUTION

Medical indigence is not a single or a simple problem. Finding a solution is not the responsibility of any one group or segment of society, nor is there "one best way" of addressing the issue. A lasting solution will require efforts by the private sector--by providers, insurers, employers and individuals--and by the public sector--by federal, state and local government. Above all it will require a commitment by the public to find and put in place the mechanisms needed to address the problem.

The dimensions of the issue can be described by looking at four sets of facts:

- The size and characteristics of the uninsured population. In 1983 approximately 32 million Americans were without health insurance and were not covered by public programs. Of these, the majority were employed or were the dependent of someone who was employed. Two-thirds of the uninsured have limited incomes and are unable to purchase private insurance.

- The declining adequacy of Medicaid. Ten years ago, Medicaid covered nearly two-thirds of those whose income fell below the poverty level. Now, Medicaid covers less than 40 percent of the poor. In addition, Medicaid has become principally a program of supplemental insurance for Medicare beneficiaries, covering those services that are not provided by Medicare, e.g., long term and primary care.

- Rapid growth in uncompensated and unsponsored care. Between 1980 and 1984, unsponsored care--care provided to patients unable to pay that must be subsidized by privately insured patients--more than doubled. Uncompensated care is rising more rapidly than any source of hospital revenue.

- Declining sources of private subsidy. Between 1980 and 1984, revenue from private sources rose only 40 percent, leading to a situation in which higher unsponsored care costs had to be spread over a smaller base. In addition, competitive pressures reduced the ability of hospitals to shift unsponsored care costs to private insurers.

These trends are leading, inevitably, to a crisis in care for the medically indigent. No single course of action will be either appropriate or sufficient. Instead, a combination of actions must be taken to address the causes of the impending crisis.

The private sector can take action to make affordable private insurance more available and reduce the number of persons without health insurance. These actions can, and should be, supported by government policies that encourage individuals and employers to offer health insurance as an employee benefit and to extend coverage to all members of an employee's family. Government can also encourage and support the efforts of private insurers to develop methods of extending private insurance coverage to the medically uninsurable and those who are unable to purchase insurance through their employers.

Although expanding the availability of private insurance is important, a significant number of individuals will always be uninsured and will need direct public assistance. In the long term, the most effective method of providing this assistance is through the restructuring and strengthening of Medicaid. Structurally, the Medicaid program should be reorganized into three distinct programs. Each of the program's components--supplemental acute care coverage and long term care coverage for Medicare beneficiaries, and acute care coverage for the non-Medicare poor--present unique problems that would be better addressed through separate programs. Financially, a stable source of funding that broadly and equitably distributes the cost of the programs across all Americans should be identified and put in place.

These reforms will not be put in place overnight. Until they, or comparable measures, have been instituted, there will continue to be a role for other state and local government programs, as well as a need for continued reliance on private insurers to subsidize the care provided to patients who do not receive governmental assistance.

ACCESS TO HEALTH CARE ACT OF 1986

The Access to Health Care Act of 1986 proposes five initiatives to address the issue of medical indigence. In general, I support these initiatives, which are consistent with many of the recommendations of the AHA Special Committee on Care for the Indigent. An underlying cause of the developing crisis in care for the medically indigent is the inability of many individuals and families to obtain insurance coverage through their employers or on their own. A symptom of the growing inadequacy of private insurance and Medicaid coverage is the rapid increase in the amount of uncompensated care provided by hospitals. Three of the proposed initiatives (H.R.4742/S.2402/S.2403) would increase private insurance coverage or provide a source of coverage for individuals unable to obtain private insurance. One of the proposals would provide a source of funding for uncompensated care cost--a short-term measure that may be necessary while other, more effective methods of addressing the issue of medical indigence are developed. And one of the initiatives would encourage innovative methods of financing and delivering care to the medically indigent.

Insurance Pooling Arrangements

Approximately two-thirds of the uninsured are either employed, but uninsured, or are uninsured dependents of employed and insured individuals. Some of these individuals are unable to obtain insurance because they suffer from chronic diseases, but the majority do not have the opportunity to obtain insurance through their employers and are unable to afford individual insurance. The proposed pooling arrangements would address both of these problems by spreading the cost of insuring these groups across all participating insurers. The use of a tax incentive to encourage participation by all insurers and self-insured businesses will foster greater equity, and the exemption for small employers will prevent adverse effects on the ability of small employers to continue providing insurance to their employees.

The proposal is generally well designed and incorporates some of the recommendations of AHA's Special Committee. However, the major impact of this proposal, if implemented, will be to expand coverage for the medically uninsurable. These individuals are a very small proportion of the uninsured. The vast majority of the uninsured are individuals with limited means who are unable to afford individual insurance. As the premium to be charged these individuals is likely to be based on individual coverage, many of them will be unable to afford the coverage offered by the pool unless their employers decide to make such insurance available as a paid or optional employee benefit. Nonetheless, the development of such pools is an important step in addressing a major cause of medical indigence.

Uncompensated Care Pools

The second proposed initiative is the mandate for states to create uncompensated care pools or other arrangements to provide health care coverage to all state residents. The penalty for failure to create such a program is the denial of Medicare payment to hospitals located in a state without a program or the reduction in federal funds available to support the state's Medicaid program or other programs supported by the Public Health Service. Of these two enforcement methods, the reduction in funds provided to state government is the more appropriate because only the state has the authority to create the necessary government programs.

To the extent that the states adopt programs to ensure health care coverage to all state residents, a major step toward a lasting solution to the indigent care program will be taken. Uncompensated care pooling arrangements may be necessary in the short term, and are being used in a number of states today. The critical issue in creating such programs is how they will be funded. In examining this alternative, however, the AHA Special Committee concluded that they provided a second-best solution. The strengthening of Medicaid programs is, in the long term, the most efficient and effective use for public funds. Although the proposed legislation permits the state to establish limits on the amount of a hospital's uncompensated care that will be recognized by the pool, if a significant percentage of total uncompensated care costs is recognized, the cost could easily be billions of dollars. It is essential that the costs be spread broadly and equitably through the use of a funding source that ensures participation by all citizens.

Extension of Private Insurance Coverage

The third initiative in the proposed legislation builds upon a provision of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), which requires, as a condition for deductibility of employer contributions to health care plans, that all employers provide their employees with the opportunity to purchase continuation coverage for themselves and their families for a period of 18 months after they they are laid off. This proposed legislation would lengthen the period of continuation coverage from 18 to 22 months, and would require employers to pay for the first four months of coverage on the same basis that they paid for coverage while the employee was on the payroll. The bills also would require an open enrollment period for an employee and his or her spouse whenever the spouse loses health insurance coverage as a result of a layoff.

This provision has generated considerable comment from business. As a major employer, in fact the largest employer in the state of Utah outside of government, I support this proposal. However, small employers may have difficulty complying with the requirement to pay for coverage, even for the limited period of four months. Consequently, a hardship exemption might be appropriate for employers with small work forces.

Tax Incentives for Self-employed

The deductibility of health insurance premiums for purposes of both personal and corporate income taxation has arguably been the most important factor behind the growth of private health insurance coverage. The proposed legislation would extend these incentives to self-employed owners of small businesses. This step is entirely appropriate, and was strongly recommended by AHA's Special Committee.

Demonstration Projects

Finally, the legislation authorizes demonstration projects on ways to reduce health insurance costs for small employers. These employers present a unique challenge to the increasingly competitive private-sector system of health care financing. AHA strongly supports such efforts to encourage the development and testing of new ideas.

MEDICAID MATERNAL AND INFANT AMENDMENTS OF 1986

The initiatives included in the Access to Health Care Act of 1986 do not involve any expenditure of federal funds or expansion of federal programs. They would, however, result in a substantial increase in expenditures by state government and potentially by private insurers and employers. The Medicaid Maternal and Infant Amendments of 1986 are a more modest, but nonetheless important, incremental step. Not only is the proposed change in Medicaid eligibility policies good health policy, it is also good fiscal policy. Expanding the coverage of maternal--particularly prenatal--and child health services should result in lower total expenditures.

As noted by ~~the~~ AHA Special Committee, Medicaid now covers less than 40 percent of the population living below the federal poverty level. And one-third of the uninsured are without any form of health insurance coverage. Many of the uninsured are mothers and children. Studies have demonstrated that every dollar invested in prenatal services, for example, results in savings of between four and six dollars in later medical expenditures. However, because Medicaid eligibility is linked to categorical benefit programs, states cannot substantially expand Medicaid eligibility without also increasing cash payments. Pregnant women not receiving AFDC (Aid to Families with Dependent Children) can be covered under state programs, but without a federal match. They can also be covered under state medically needy programs if their health care needs cause them to "spend down" to the medically needy standard. But applied to pregnant women, the requirement effectively precludes coverage of cost-effective prenatal services that are needed early in the pregnancy.

The proposed change in Medicaid policy allows states to establish separate eligibility criteria for their Medicaid and welfare programs. States will be able to provide access to medical care for a critical group without increasing the cost of their public assistance programs. AHA believes that this is a constructive change that continues the initiatives already taken by Congress to reform and strengthen the Medicaid program.

CONCLUSION

In summary, the various legislative proposals that are before this committee today are an important, positive step to address a growing crisis in care for the medically indigent. They clearly recognize that the problem of medical indigence is complex, and that no single solution will be effective. They also recognize that the causes, and not just the symptoms, of medical indigence must be addressed. And they recognize that a lasting solution will require action by both the private sector and government. The proposals themselves raise many issues but provide a strong foundation on which to build. I am pleased by this opportunity to present my views on this difficult but important subject, and assure you that the AHA is committed to assist you in refining the proposals and working toward an enduring solution.

The CHAIRMAN. Mr. Maher?

Mr. MAHER. Good morning, Senator Hatch, Senator Kennedy. I have with me this morning James Klein, who is the manager of Pensions and Employee Benefits with the U.S. Chamber.

We are pleased to be here to testify on behalf of the Chamber on the Access to Health Care Act.

The workplace, as you know, is the source of 85 percent of all private health insurance coverage in the country, and accordingly, because we see the importance of employer-provided health care coverage, and because we want that role expanded and not diminished, we are committed to overcoming barriers to health care availability.

As a nation, we cannot be satisfied when millions of Americans go without adequate health care coverage, nor when charity care is denied because particular institutions have a revenue squeeze.

However, to the extent that Government programs designed to serve the needy are not adequate, hospital squeezes in part caused by less-than-adequate Medicaid reimbursement, and that upward of 75 percent of those without coverage are employed or dependents of employed persons, in fashioning remedies we believe great care must be taken to spread fairly the resulting societal costs. In particular, those health care purchasers already providing coverage and paying a fair reimbursement for services rendered should not be singled out by having those payments serve in effect as a tax base for the levying of a surcharge necessary to subsidize coverage for the uninsured.

There are two intrinsic flaws in such a remedy. First, taxing directly or indirectly health care payments of businesses offering health coverage to raise money to subsidize coverage for others shifts the burden to those who are doing the most to address the access problem.

Second, tax dollars funding Government health care programs are generally derived from tax levies based in one way or another on the accepted concept of ability to pay; in other words, it either comes from income taxes or payroll taxes. Either basis reflects somewhat on an entity's ability to generate revenue.

Such is not the case, however, with respect to a business' health care payments. A mature company, for example, providing health care coverage not only for employees but for retirees as well, generates health care payments which may in no way be a reflection of the business' ability to generate revenues from the efforts of its existing, current work force. To impose a tax on that company to raise money to cover a societal problem greater than would be imposed on a comparable-sized, less mature company with fewer retirees, or a company that offers no retiree coverage, or worse, to ignore in the taxing process those who have contributed to the access problem by not offering coverage at all, is not equitable.

Addressing some of the bill's specifics, the provisions extending a business tax deduction for health care purchased by unincorporated businesses and the self-employed builds on the strength of the voluntary benefit system. It treats small businesses and the self-employed more equitably, and will result in increased availability of health coverage, and the chamber therefore endorses this targeted extension of tax benefits.

With regard to the extension of coverage for former workers, while the chamber applauds the fact that many of our member companies, including my own, voluntarily provide extended benefits to laid-off workers, the chamber opposes mandating such coverage, particularly when it is not part of a broad policy change designed to address the totality of the health care coverage issue.

As appealing as mandated health care coverage for former employees may seem, coupled with more and more State-sponsored mandates, its costs could provide a great disincentive for employers to offer health insurance to employees, and it also could be a further reason for employers considering the deletion of coverage to do so. And neither would inure to the benefit of either employed or unemployed workers, or accomplish the public policy objective of the bill's sponsors.

Regarding risk pools, the Chamber is currently actively studying this issue and finds the concept meritorious. However, since many risk pool participants will be individuals with a higher likelihood of incurring above-average health care costs, the premium they pay almost certainly will not be sufficient to pay for the actual expenses for providing care.

The question therefore is who provides the subsidy. Under Senate bill 2402, those businesses already providing health care coverage will pay a major portion of any funding shortfall. As with mandated coverage, a risk pool deriving an inequitable subsidy from business may well reduce the number of businesses offering coverage, thereby increasing the number of pool participants—again, not the public policy result envisioned by the bill's sponsors.

The Chamber commends the provisions of the bill which call for demonstration projects on ways to lower health care costs for small businesses. As we search for solutions to the access problems, it is extremely important to focus on this group, since as stated earlier, their employees represent a significant portion of the uninsured population.

In conclusion, access to basic health care benefits for all citizens should continue to be a national goal. There is an obvious role for Government in fashioning the means to accomplish this goal, specifically, financing care for the elderly and the poor. Business likewise has shown itself capable of playing a significant role by voluntarily providing coverage for a major portion of this country's employee population. Building on this framework, we should be able to accomplish the desired result of universal access in a manner which spreads the costs fairly.

Accordingly, rather than pursue a policy of addressing ad hoc gaps in coverage, we recommend that Congress conduct a systematic review of access and coverage gaps in a manner that permits an assessment of priorities, alternative strategies, associated costs, and appropriate Federal incentives.

Our fundamental concern is that a piecemeal approach to solving this most serious social problem fails to take into account the potential economic impact on American business and the implications for maintaining a fiscally sound employment-based health insurance system, which is so vital to the attainment of the ultimate objective.

The Chamber stands ready to assist in gathering and analyzing the data needed to frame a more comprehensive solution and to work with this committee in support of enabling legislation.

Thank you.

The CHAIRMAN. Thank you so much, Mr. Maher.

[The prepared statement of Mr. Maher follows:]

STATEMENT
on
BARRIERS TO HEALTH CARE
before the
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
for the
U.S. CHAMBER OF COMMERCE
by
Walter B. Maher
July 16, 1986

Mr. Chairman and members of the committee, my name is Walter B. Maher. I am Director of Employee Benefits and Health Services for Chrysler Corporation. I serve as a member of the Chamber's Health Care Council and as Chairman of its Task Force on Retiree Health Care. Accompanying me today is James A. Klein, the Chamber's Manager of Pension and Employee Benefits.

I am pleased to testify on behalf of the U.S. Chamber of Commerce on the topic of barriers to health care, and specifically on one legislative proposal, the Access to Health Care Act, S. 2402, which intends to address the barriers faced by those unable to obtain affordable health insurance, as well as the barriers which are the product of uncompensated care. The goal of an accessible, affordable, quality health care delivery system is an important one for the nation, and the Chamber shares the committee's interest in this matter. Toward this end, the Chamber's Health Care Council has established various task forces, including one on uncompensated care, to assist public policy decision-making in this area.

Over the years, businesses in general, together with their employees, have responded in an overwhelming manner to the tax incentives offered to foster a private health insurance system in America. Data suggest that the workplace is the source of 85% of all private health insurance coverage. Accordingly, because we see the importance of the contribution of businesses in providing health care coverage — and because we want that role of the private sector expanded, not diminished — we are committed to overcoming barriers to health care availability. However, we believe it is critical that in fashioning a remedy for this truly national issue, that Congress does not penalize businesses which have removed barriers by offering employees health coverage, that it does not provide a basis for businesses to elect not to offer or to cease offering coverage, and that it does not ignore the fact that upwards of 75% of those who are uninsured are employed or are the dependents of employed persons.

SUCCESS OF PRIVATE HEALTH-CARE BENEFITS SYSTEM

Employer-sponsored health care benefits have proven a valuable and enormously successful protection for workers and their families. Such health plans have the flexibility to meet the needs of workers within the total compensation resources of their employers. The federal government has been vital to the success of this private-sector approach by providing broad tax incentives for employers to offer group health-care benefit plans for their employees without dictating the terms of these plans.

Employers currently spend an estimated $100 billion each year on health care for their employees. As health-care costs have escalated at an alarming rate over the past decade, business, as the purchaser of health care on behalf of most working-age Americans and their dependents, has taken an active role in the redesign of health-insurance plans to assure the efficient delivery of quality care. Central to these efforts has been the stimulation of competition in providing health care by offering workers a choice of delivery systems. At my own company, for example, we have recently completed an open enrollment wherein most employees had the opportunity to elect between a standard fee-for-service plan, a health maintenance organization (HMO), and, for the first time, a preferred provider organization (PPO). Whereas prior to the enrollment 91% of our employees in those areas where choices were available had elected the fee-for-service plan and only 9% the HMO option, we now have 12% of employees in HMO's, 29% in PPO's, and the fee-for-service share has dropped to 59%. Inherent in the success of the offering of such alternatives by employers is the flexibility they have had in the design of the alternative health plans.

Accordingly, the Chamber believes that the present system of voluntary, nondiscriminatory, private-sector employee health care benefit plans which can vary in accordance with the needs of employers and employees should be nourished and built upon. For this reason, the Chamber has opposed federal or state government requirements mandating plan design or financing, whether applicable to insured or self-insured plans, because they limit flexibility and raise costs. We fully recognize that, as a nation, we cannot be satisfied when millions of Americans go without adequate health care coverage, nor when charity care is denied because particular institutions have a revenue squeeze. However, to the extent that government programs designed to serve the needy are not adequate and the hospital revenue squeeze is in part caused by less-than-adequate reimbursement from, for example, Medicaid programs, in fashioning remedies great care must be taken to spread fairly the resulting societal costs. For example, those health care purchasers already paying a fair reimbursement for services rendered should not have those payments serve, in effect, as a tax base for the levying of a surcharge necessary to subsidize coverage of the uninsured.

There are two intrinsic flaws in such a remedy. First, taxing, directly or indirectly, the value of health care payments of those businesses offering health coverage to raise money to subsidize coverage for others who are not employees, shifts the burden to those who are doing the most to address the access problem. Second, the tax dollars serving to fund government health programs are generally derived from tax levies based in one way or another on the accepted concept of "ability to pay," i.e., either from income taxes or payroll taxes. From the standpoint of business, either basis reflects somewhat, though not fully, on an entity's ability as a going concern to generate revenue. Such is not the case, however, with respect to business health care payments. A mature company, for example, providing health care coverage not only for the employees, but for retirees as well, generates health care payments which may in no way be a reflection of the business ability to generate revenues from the efforts of its current work force. To impose a tax on that company to raise money to cover a societal problem is not equitable. This is not, however, a problem without a solution. Before discussing some of our ideas, however, let me comment on certain provisions of the Access to Health Care Act.

TAX INCENTIVES FOR THE SELF-EMPLOYED

The proposed legislation, which would extend a business tax deduction for health care purchased by unincorporated businesses — which are virtually all small businesses — and the self-employed, builds on the strengths of the voluntary benefits system. It treats small businesses and the self-employed more equitably and will result in the increased availability of health care coverage. The Chamber endorses this targeted extension of tax benefits.

The Chamber is pleased that the Senate version of the Tax Reform Act, H.R. 3838, also allows for a tax deduction for the self-employed, and the Chamber has urged members of the Committee on Ways and Means to support that aspect of the Senate tax measure when it is considered in conference.

EXTENSION OF HEALTH COVERAGE FOR FORMER WORKERS

Only three months ago, Congress enacted — and the President signed into law -- the Consolidated Budget Reconciliation Act of 1985 (COBRA), which contained provisions requiring employers to continue to make available health-care plans to various categories of former employees and their family members (at the individual's own expense) for periods ranging from 18 to 36 months. Those continuation of coverage requirements were attached to the budget measure with little open Congressional discussion or debate. Now, S. 2402, and a companion measure in the House, have been introduced and would require employers to pay for benefits for up to four months for former employees and their families.

While the Chamber applauds the fact that many of our member companies voluntarily provide extended benefits to laid-off employees, some for periods well in excess of four months, the Chamber opposes mandating such coverage, particularly when it is not part of a broad policy change designed to address the totality of the health care coverage issue. Obviously, incremental progress is important, especially for an issue as sensitive as health care protection, and we commend the bill's sponsors for causing us all to examine the issue in help developed solutions. However, an intended incremental gain resulting from government-mandated coverage may well prove to have a negative result. If further mandates are imposed, employers, already dedicating 37% of payroll costs to employee benefits, might well try to keep costs stable by diminishing or abolishing health or other types of employee benefits.

Employers face an increasingly complex and costly array of benefit mandates. The number of state-mandated benefit laws has increased from fewer than 50 in 1974 to over 600 in 1985. State mandates encompass a host of provider groups and various treatment categories. In some instances, the states mandate coverage; in other instances, the states require that the coverage be made available at the employer's option.

An increasing number of state mandates require that mandated benefits be offered to all residents irrespective of where the insurance policy is issued. Consequently, employees of multi-state employers are covered by different sets of benefits based solely on residence rather than on labor-management agreements.

For the above reasons, the Chamber is pleased that several states have recently questioned the wisdom of the mandated benefits strategy. For example, since 1984, the state of Washington has required a social and financial impact assessment for proposed mandates. Similar legislation was enacted this year in Arizona and Oregon, and bills requiring impact assessments have been introduced in at least eight other states.

As appealing as mandated health care coverage for former employees may seem, such a requirement does come at a significant cost to the voluntary employee benefits system. Coupled with more and more state-sponsored mandates, it could provide a great disincentive for employers to offer health insurance to employees. It also is further reason for employers considering the deletion of coverage to do so, particularly since a principal reason employees are terminated is due to adverse business circumstances necessitating work force reductions.

In addition, the prospect of paying for continued health care coverage for the spouse of a former employee, when that spouse may be eligible for coverage from his or her own employer, and for employees who voluntarily quit work, is particularly onerous.

Obviously, no reliable data yet exists on the number of companies that will curtail or abandon health or other employee benefits as a result of the continuation of coverage requirements of COBRA. However, on an anecdotal basis, the Chamber can confirm that numerous employers are outraged by these mandates, and some have stated they are considering reducing the benefits they offer to employees. Faced with the mandates of S. 2402, which involve an even greater direct cost to employers, the curtailment or abolition of benefit plans could grow. That certainly would not inure to the benefit of either employed or unemployed workers or accomplish the public policy objective of this bill's sponsors.

RISK POOLS FOR THE MEDICALLY UNINSURABLE

The Chamber is studying actively the "insurance risk pool" concept as part of the work of our special Task Force on Uncompensated Health Care. While we have not yet adopted a policy position on the subject, the concept of risk pools has merit as a way to provide coverage for those finding themselves excluded from existing modes of coverage, such as those viewed as medically uninsurable.

However, since the risk pool participants will be individuals with a high likelihood of incurring above-average health care costs, the premium they pay (i.e., 150% of the cost of individual health insurance) almost certainly will not be sufficient to pay for the actual expense for providing care. The question, therefore, is, who provides the subsidy? Under S. 2402, those businesses providing health care coverage, both self-insured and those purchasing group insurance, will pay a major portion of any funding shortfall.

Paradoxically, those companies that are providing health benefits to their employees, many times without excluding pre-existing conditions, also will be incurring an unknown and limitless risk for paying for health care coverage for other individuals -- some of whom may be the employees of their competitors.

As with mandated coverage, a risk pool which derives an inequitable subsidy from business may well reduce the number of businesses offering coverage, thereby increasing the number of pool participants. Again, not the policy result envisioned by this bill's sponsors.

The risk pool concept and its effectiveness in the 10 states that currently have pools should be scrutinized carefully. Our Task Force is currently doing this. A carefully-designed, fairly-funded risk pool may well ameliorate part of the uninsured health care problem. To do so, however, will require that the pool be financed in a way not punitive to employers currently providing coverage for their employees, and also that the health care delivery system employed be one designed to provide cost-effective treatment.

DEMONSTRATIONS ON LOWERING HEALTH-CARE COSTS FOR SMALL BUSINESSES

The Chamber commends the provision of S. 2402 which calls for demonstration projects on ways to lower health care costs for small businesses. Traditionally, lack of coverage is greatest among smaller companies, due to their diminished ability to pay for and administer employee benefits programs. As we search for solutions to the access problem, therefore, it is extremely important to focus upon smaller employers since, as stated earlier, their employees represent a significant portion of the uninsured population.

Recognizing the importance of this issue, the Chamber's affiliated National Chamber Foundation has conducted extensive research on lowering health care costs. In addition, the Chamber's Clearinghouse on Business Coalitions for Health Action has been active in advising small firms on ways to provide health care benefits in the most comprehensive and efficient manner. Further, a number of state and local chambers of commerce have embarked upon innovative programs to show small businesses how they can afford to offer health care coverage to their employees. The Chamber is gratified that S. 2402 recognizes this excellent work by proposing demonstration grants and recommending that chambers of commerce be among the types of organizations to receive such grants.

STATE INSURANCE AND UNCOMPENSATED CARE PLANS

The Chamber shares the committee's concern about uncompensated hospital care, particularly as it may affect prospectively on a hospital's willingness to provide charity care. We are concerned, however, by the bill's open-ended proposal that directs states to establish insurance programs for the uninsured and underinsured. A number of states currently are experimenting with various hospital uncompensated care financing mechanisms. Any solutions adopted in this area, however, must not discourage attention to hospital care costs or underfunding of costs by Medicaid and Medicare. At this time, therefore, federally-mandated state insurance plans appear premature.

CONCLUSION

Access to basic health care benefits for all citizens should continue to be a national goal. There is an obvious role for government in fashioning the means to accomplish this goal, specifically, financing care for the elderly and the poor. Business, likewise, has shown itself capable of playing a significant role by voluntarily providing coverage for a significant portion of this country's employee population. Building on this framework, we should be able to accomplish the desired result of universal access in a manner which spreads the cost fairly. Accordingly, rather than pursuing a policy of addressing ad hoc gaps in coverage, we recommend that Congress conduct a systematic review of access and coverage gaps in a manner that permits an assessment of priorities, alternative strategies, associated costs, and appropriate federal incentives. Fiscal realities, in both public and private sectors, compel us to set priorities even among socially desirable goals.

Our fundamental concern is that a piecemeal approach to solving this most serious problem fails to take into account the potential economic impact on American business and the implications for maintaining a fiscally-sound employment-based health insurance system -- a system so vital to the attainment of the ultimate objective. The Chamber stands ready to assist in gathering and analyzing the data needed to frame a more comprehensive solution and to work with this committee in support of legislative provisions that will increase the availability and affordability of private health insurance coverage which is financed in a manner which is fair and which recognizes economic pressures facing U.S. employers. Thank you.

The CHAIRMAN. Ms. Santilli?

Ms. SANTILLI. Mr. Chairman, Senator Kennedy, and members of the committee, my name is Nancy Santilli, and I am a member of the board of directors of the Epilepsy Foundation of America.

I am here today representing not only the Coalition for Health Insurance Availability, but more importantly, the millions of Americans who are represented by these organizations.

The Coalition for Health Insurance Availability wishes to express our strong support for the pooled risk health insurance provisions contained in S. 2402, the Access to Health Care Act. A copy of our coalition statement and list of its members is attached to my testimony.

I would like to thank you, Senator Kennedy, for your leadership and the other cosponsors of this legislation for caring.

We believe that all Americans should have access to health care, yet 37 million people—1 out of every 6 citizens—remain uncovered by either public or private health plans.

Louis Harris & Associates earlier this year released the findings of the first comprehensive survey of the attitudes and beliefs of people with disabilities or severe health conditions. The survey found that 18 percent, or an estimated 2.3 million of the individuals with disabilities or severe health problems who were age 16 through 64 are not covered by either private or government health insurance.

It is important for us to note that the Access to Health Care Act is not the solution to the health care needs of all these people, but it is a solution for a segment of these and other uninsured Americans.

It is the solution for people who are willing and able to pay significantly higher premiums than the standard-risk individuals in order to obtain health insurance, but have found private insurers unwilling to extend coverage to them.

It is the solution for people under 65 who upon retirement are no longer covered by group health plans and are subsequently denied individual coverage due to preexisting conditions. At the same time that they need health insurance the most, they are left without it.

It is the solution for a parent of a child with a serious medical condition such as cystic fibrosis, who is now frequently trapped in his or her current job, since the health plan offered by the new employer does not extend coverage to the child's preexisting health condition.

As an associate director of the Comprehensive Epilepsy Program at the University of Virginia, I work with far too many families who must wrestle not only with the emotional trauma which accompanies serious illness or disability, but the added stresses stemming from financial obligations which far exceed the family's ability to pay.

Risk pools have now been enacted in 10 States. Early experience has shown that the goals of having the pools be self-supporting, limiting the pools to high-risk individuals, and capping premiums cannot be achieved at the same time.

It has become increasingly apparent that for risk pools to work, the total out-of-pocket costs, such as premiums, deductibles, and coinsurance payments, must be sensitive to the individual's ability to pay. The issues of affordability and not just accessibility must be addressed if risk pools are to work.

The Epilepsy Foundation of America, joined by many other members of the Coalition for Health Insurance Availability, would like to recommend that the committee require States to assist lower income individuals gain access to the risk pools through an income-based sliding scale subsidy of both the premium and out-of-pocket expenses. States at their option might be authorized to provide such payments based upon income less impairment-related work expenses as defined by the Social Security Act to individuals through the Medicaid Program.

Consider, if you will, the problems experienced by "Theresa H." Theresa is a 20-year—old resident of Winthrop, MA. Theresa earns $7,500 a year working as a short-order cook. She is paid the minimum wage, and her employer does not offer health benefits. Theresa happens to have epilepsy, which has been cited as the reason for her being denied health insurance.

Even after S. 2402 is enacted, it is quite likely that Theresa would find access to the health risk pool effectively denied unless the State of Massachusetts decides to provide a low-income subsidy to her. Under the existing Indiana plan, she would have to pay $2,432, or 32 percent of her pretax income.

While the plans may provide comparable benefits, people with disabilities and serious medical conditions have needs which go far beyond those which traditional plans were designed to meet. Such needs include durable medical equipment purchase and repair, prosthetic devices, disposable medical supplies, physical or occupational therapies and personal care attendants.

Society as a whole already bears the cost attributable to the lack of adequate medical care coverage through lost productivity, uncompensated care and individual and family stresses. The question, therefore, is not whether such costs shall be met, but how.

Risk pools do offer a partial solution to the health care needs of individuals who find health insurance inaccessible. The remaining sections of S. 2402 which also address health care access for millions of Americans are commendable.

While the Coalition for Health Insurance Availability has no specific recommendations on these sections, we applaud your efforts to broaden the base for health insurance coverage and access to health care.

Access to health care insurance provides access to quality health care. Conversely, the denial of health insurance often means the denial of quality health care. The Coalition for Health Insurance Availability is prepared to work closely with the committee to ensure the risk pooling provisions of the Access to Health Care Act are enacted this year.

Thank you.

[The prepared statement of Ms. Santilli follows:]

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STATEMENT RESPECTFULLY SUBMITTED
TO THE
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

BY

NANCY SANTILLI, RN, PNP, MN
ASSOCIATE DIRECTOR OF THE COMPREHENSIVE EPILEPSY PROGRAM
UNIVERSITY OF VIRGINIA MEDICAL CENTER
CHARLOTTESVILLE, VIRGINIA

ON

THE ACCESS TO HEALTH CARE ACT OF 1986 (S. 2402)
ON BEHALF OF THE
COALITION FOR HEALTH INSURANCE AVAILABILITY
AND
THE EPILEPSY FOUNDATION OF AMERICA

JULY 16, 1986

The Coalition for Health Insurance Availability

Mr. Chairman, Senator Kennedy and members of the Committee, my name is Nancy Santilli, and I am a member of the Board of Directors of the Epilepsy Foundation of America.

I am here today representing not only the Coalition for Health Insurance Availability, a coalition of 45 national organizations working to ensure that every American has access to quality health care and affordable health insurance, but more importantly, the millions of Americans who are represented by these organizations -- people with prevalent conditions such as arthritis, cancer, cerebral palsy, diabetes, epilepsy, heart disease, mental retardation, mental illness and sickle cell anemia as well as people with rarer conditions such as amyotrophic lateral sclerosis (ALS), cystic fibrosis, immune deficiency, multiple sclerosis and tourette syndrome.

The Coalition for Health Insurance Availability wishes to express our strong support for the pooled risk health insurance provisions contained in S. 2402 -- The Access to Health Care Act. A copy of our coalition statement and list of members is attached to my testimony.

Before proceeding further, I would like to thank you, Senator Kennedy, for your leadership on behalf of the millions of Americans who have been denied health insurance coverage due solely to their pre-existing medical conditions. We thank you and the other cosponsors of this legislation for caring.

THE DIMENSION OF THE PROBLEM

The Epilepsy Foundation of America, together with many other members of the Coalition, has long supported the enactment of a national health care system which makes access to health care services a right for all Americans. We believe that all Americans should have access to quality health care. Yet 37 million people - one out of every six citizens - remain uncovered by either public or private health plans.

This statistic, however staggering, fails to convey the human dimension of the problems - financial, emotional and physical - experienced by the individual and family who do not have access to appropriate health care.

These individuals include a broad cross-section of the poor and not so poor, the young and the almost 65, the healthy and the seriously ill or disabled. Many of these individuals, whose access to health care is all too frequently limited to local clinics or emergency rooms of public hospitals, are clearly not receiving the same level of care as the insured population. Their care places a serious financial burden on their own resources as well as on the uncompensated care problem faced by health care providers.

The Medically Uninsured

Louis Harris and Associates, earlier this year, released the findings of the first comprehensive survey of the attitudes and beliefs of people with disabilities or severe health conditions. This survey, based on 1,000 interviews, found that 18 percent or an estimated 2.3 million of the individuals with disabilities or severe health problems who are aged 16 through 64 were not covered by either private or government health insurance. To this number of working age individuals must be added an unknown number of children with serious health conditions or disabilities whose parents are unable to provide either insurance coverage or whose policies preclude expenditures stemming from the child's pre-existing condition.

Risk Pools: A Part of the Solution

Section 2 of the Access to Health Care Act provides the necessary impetus for states to enact pooled risk health insurance plans. While the Coalition would prefer enactment of legislation _ensuring_ health care coverage of every individual, we support the establishment of risk pools since they offer the _possibility_ of insurance coverage to a segment of the population -- the medically uninsured -- who are often denied coverage today.

It is important for us to note that the "Access to Health Care Act" is not _the_ solution to the health care needs of all these people but it is _a_ solution for a segment of these and other uninsured Americans.

It is the solution for people who are willing and able to pay significantly higher premiums than standard risk individuals in order to obtain health insurance but have found private insurers unwilling to extend coverage to them.

It is the solution for people under 65, who upon retiring, are no longer covered by an employment-based group health plan and are subsequently denied individual coverage due to a pre-existing condition such as cancer, heart disease or multiple sclerosis. At the time they need health insurance most, they are left without it.

It is the solution for the parent of a child with a serious medical condition such as cystic fibrosis who is now frequently trapped in his or her current job. A new job or the opportunity to move to a different city must often be refused because the health plan offered by the new employer will not provide coverage of the child's pre-existing health condition.

This loss of professional flexibility and economic opportunity also applies to the working adult who has a pre-existing medical condition. Not only is this unfair but it adds tragically to the economic and emotional burdens faced by the family.

As Associate Director of the Comprehensive Epilepsy Program at the University of Virginia Medical Center, I work with far too many families who must wrestle not only with the emotional trauma which accompanies serious illness or disability but the added stress stemming from financial obligations which far exceed the family's ability to pay.

Affordability As Well As Accessibility Must Be Addressed

Risk pools have now been enacted in ten states. At the beginning of 1985, six states (Connecticut, Florida, Indiana, Minnesota, North Dakota and Wisconsin) had pools in operation. Montana and Nebraska passed implementing legislation in 1985 while Iowa and Tennessee did so this year. Each program was intended to be financed primarily through subscriber premiums. Early experience has shown that the goals of having the pools be self-supporting, limiting the pools to high risk individuals and capping premiums cannot all be achieved at the same time.

It has become increasingly apparent that for risk pools to work, the total out-of-pocket costs (premiums, deductibles and co-insurance payments) must be sensitive to the individual's ability to pay. Section 2(c) of the "Access to Health Care Act" contains several essential provisions specifying the levels of coverage which the risk pools must meet in order to be in compliance. For instance, there is a limit of $1,500 for out-of-pocket expenses and premiums cannot exceed 150 percent of the average rate for individual as differentiated from group policies. Unfortunately, it is likely that this cap will become the only rate.

The bill, however, does not consider premium payments as an out-of-pocket expense. The issue of affordability not just accessibility must be addressed if risk pools are to work.

The section further specifies that "nothing in this paragraph shall be construed as preventing a State or other entity from providing for payment of part or all of the premium of an enrollee and from varying the amount of such payment based on the enrollee's income or other basis."

The Epilepsy Foundation of America, joined by many other members of the Coalition for Health Insurance Availability, would like to recommend that the Committee require states to assist lower income individuals gain access to the risk pool through an income based sliding scale subsidy of both the premium and out-of-pocket expenses. We are pleased to note that the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO) recognizes the importance of this provision and supports this strengthening of the risk pool concept.

States, at their option, might be authorized to provide such payments based upon income less impairment-related work expenses (as defined by the Social Security Act) to individuals through the Medicaid program.

Theresa H.

The national offices of the organizations belonging to our coalition as well as our affiliates and chapters throughout the United States frequently receive calls from individual's experiencing problems obtaining and/or affording health insurance.

Consider, if you will, the problems experienced by Theresa H. Theresa is a 20 year old resident of Winthrop, Massachusetts who has participated in various programs offered by the Epilepsy Association of Greater Boston. Theresa earns approximately $7,500 a year working as a short-order cook. She is paid the minimum wage. Her employer does not offer health benefits. Theresa happens to have epilepsy which has been cited as the reason for her being denied health insurance.

Even after S. 2403 is enacted, it is quite likely that Theresa would find access to the health risk pool effectively denied unless the state of Massachusetts decides to provide a low-income subsidy to her. For instance, under the existing Indiana plan, she would have to pay $2,432 (reflecting a premium of approximately $1,432 and a deductible of $1,000) before the risk pool would provide 80 percent coverage of her medical expenses. This would amount to 32 percent of her pre-tax income. Even if Theresa was living in Minnesota which has the most favorable risk pool terms, she would have to expend $1,432 or 19 percent of her pre-tax income before having any of her expenditures covered by the plan.

Disability-related Expenditures

The Committee must remember that even if the premium and deductible is subsidized, risk pools will not be the total solution to the health care needs of people with disabilities or serious medical conditions.

While the plans may provide comparable benefits, people with disabilities and serious medical conditions have needs which often go far beyond those which traditional plans were designed to meet. Such needs include durable medical equipment purchase and repair, prosthetic devices, disposable medical supplies, physical or occupational therapies and personal care attendants.

Societal Costs

Risk pools cannot be expected to be totally self-supporting. Minnesota's plan, which has been in operation eight years, experienced a loss of about $4.7 million in 1984, but the program provided coverage to over 10,000 people. This loss amounts to just under one percent of the total health insurance premiums paid by all citizens in a year or approximately $1.15 per Minnesota resident.

Society as a whole already bears the cost attributable to the lack of adequate health care coverage - through lost productivity, uncompensated care and individual and family stress. The question, therefore, is not whether such costs shall be met, but how.

Risk pools do offer a partial solution to the health care needs of individuals who find health insurance inaccessible. It also represents a partnership involving the individual, the private sector and the public sector.

The remaining sections of S. 2402 which also address health care access for Americans are commendable. While the Coalition for Health Insurance Availability has no specific recommendations on these sections, we applaud your efforts to broaden the base for health insurance coverage and access to health care.

Access to health insurance provides access to quality health care. Conversely, the denial of health insurance often means the denial of quality health care. The Coalition for Health Insurance Availability is prepared to work closely with the Committee to ensure the risk pooling provisions of the "Access to Health Care Act" are enacted this year.

Thank you for this opportunity to present our views.

COALITION FOR HEALTH INSURANCE AVAILABILITY

Statement in Support of the Health Insurance Risk Pooling Provisions of the Access to Health Care Act of 1986

July 16, 1986

The Coalition for Health Insurance Availability, comprised of 46 national organizations representing individuals with chronic health conditions or disabilities and older Americans, supports the provision of the "Access to Health Care Act" that will provide access to health insurance to individuals and families who are willing but unable to purchase it because of a pre-existing health condition. This legislation (S. 2402, S. 2403 and H.R. 4742) was introduced on May 1 by Senators Kennedy, Durenberger, Heinz and Riegle in the United States Senate and by Congressmen Stark and Gradison in the House of Representatives.

Many of those unable to purchase health insurance coverage are people with developmental disabilities, physical or mental impairments, and chronic health conditions. In many cases these are working people who are willing and able to pay for health insurance but are unable to purchase it because they have a pre-existing condition. In other cases they are older people who, upon leaving their employment, find they cannot purchase individual coverage. At the time they need health insurance most, they are left without it. The inability to obtain adequate insurance has serious consequences not only for these individuals but for their families as well.

The Kennedy-Durenberger-Stark bills would help solve this problem by encouraging states to make reasonably priced insurance available to those who cannot purchase it on the open market through the formation of an insurance risk pool.

Several models for an effective risk pool already exist. Ten states already have some form of risk pool offering comprehensive major medical insurance to people considered by insurers as "high risks." These states are Connecticut, Florida, Indiana, Iowa, Minnesota, Montana, Nebraska, North Dakota, Tennessee and Wisconsin. Purchasers pay into the pool like any other group health plan. If the pool experiences losses, those losses are proportionately shared by all the insurers conducting business in the state.

The Kennedy-Durenberger-Stark bills will not require the expenditure of any federal funds. This legislation simply establishes minimum standards based on the experiences of successful state pools. Each pool would be established and regulated in each state similar to other state insurance programs.

Millions of people who, because of health problems, are unable to purchase health insurance in any other fashion, would be afforded coverage. That is why we support the enactment of risk pooling legislation. The Health Insurance Association of America representing the commercial health insurance companies also supports the risk pooling provision contained in the Kennedy-Durenberger-Stark bills.

The denial of health insurance often means the denial of health care. It is critical that risk pooling legislation be enacted this year.

COALITION FOR HEALTH INSURANCE AVAILABILITY

ACLD, Inc. An Association for Children and Adults with Learning Disabilities
Alliance for the Neurologically Impaired
American Association of Retired Persons
American College of Gastroenterology
American Diabetes Association
American Foundation for the Blind
American Liver Foundation
American Medical Student Association
American Speech-Language-Hearing Association
Amyotrophic Lateral Sclerosis Association
Arthritis Foundation
Association for Retarded Citizens
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National Organization for Rare Disorders
National Rehabilitation Association
National Society for Children and Adults with Autism
National Sudden Infant Death Syndrome Foundation
National Women's Health Network
Sickle Cell Support Association
Sick People Need Insurance (SPINS)
Sick Kids Need Involved People (SKIP)
Spina Bifida Association of America
Tourette Syndrome Association, Inc.
United Cerebral Palsy Associations, Inc.

For Further Information:

Myrl Weinberg (703-549-1500) American Diabetes Association	OR	Richard Nugent (301-459-3700) Epilepsy Foundation of America

The CHAIRMAN. Well, thank you so much. I may have questions to submit in writing to all of you and would ask that you answer them as quickly as you can.

Scott, I have received numerous letters from employers around the country in opposition to the Access to Health Care Act, and since you are a large company and employer, I would like to just read one of them to you and ask for your opinion and maybe you can respond to some of the concerns.

This letter says,

> Dear Senator Hatch, I wish to express my opposition to the Improved Access to Health Care Initiative Act of 1986, which is being lumped into the 1987 budget legislation. While the Act may seem like a good idea on the surface, it contains several flaws: (1) mandating to private employers the payment of pooling claims over which they have no control; (2) establishment of State pools which are actuarially unsound; (3) employer financing of charity medical care with no cost controls to health care providers; (4) continued Federal meddling in State insurance regulations.
>
> Please do not pass this initiative in its current form. It has far-reaching effects on the private benefit system of our great country.

Would you care to respond to that?

Mr. PARKER. I would be glad to, Senator.

I certainly understand the position of that letter and also the position of the National Chamber, Senator Hatch. As an employer myself, our organization is probably the largest nongovernment employer in the State of Utah; and as a former member of the Chamber of Commerce Board, I understand business' concern about increased costs of operation.

Our problem is, as you well know, a problem in search of a financing base. How are you going to pay for those 30 million people who need insurance coverage?

Our options are very simple. It can be the Federal Government in total. It can be a Federal and State combination. We know the problems of the Federal budget. We know the stresses on the State. That leaves a couple of other simple options. We either look to employers, or we look to the providers. Providers have traditionally accepted that responsibility, but it has been easy because we have shifted it to business.

Business is now making the same point again: "Please, do not shift it to us." But we do not have many options. Either it will be a combination of employers and providers, or the Federal and State Governments will need to step up to it, even with all the pressures you have and the States have, and provide more money. There is no magic.

The CHAIRMAN. All right. Mr. Maher, how much do you estimate the access to health care legislation will cost both public and private sector groups, and how many people do you estimate would lose their jobs altogether?

Mr. MAHER. The Chamber has not completed those calculations yet, Senator.

The CHAIRMAN. Will you complete those and send them to us?

Mr. MAHER. We will definitely provide that information to you.

The CHAIRMAN. OK. And in your testimony you state that a potential impact on the access to health care legislation is that some employers may reduce health care benefits. Do you have any evidence to sustain that statement?

Mr. **Maher**. We have, and the companies are contacted and have contacted not only the Chamber but other organizations, for example, that my company belongs to. They have been contacted by organizations not only regarding this act, but some of the provisions of COBRA that impact on this issue.

I think the thrust of our statement is that business is providing so much of the insurance to the citizens of this country that we should build on that and not lay the predicate for businesses curtailing coverage.

The **Chairman**. Thank you.

Ms. Santilli, I agree with you that we need to look at ways of reducing the costs of catastrophic health care for families. And I have learned from many in Utah about this problem, and I can say that many times they fall through the cracks, or they get caught in the redtape or for some other reasons. So I am pleased that my own home State has developed a sort of pool that does seem to be working.

However, one concern I have with the revenue pool provisions in S. 2402 is section 2. It requires the State to comply with a single-model insurance pool system. That does concern me, because there are a lot of States that are aggressively pursuing developing their own models for solving this problem, and it seems to me this legislation may deter the States from coming up with innovative solutions.

What would be your opinion there?

Ms. **Santilli**. I think the legislation as it exists does give each State flexibility in creating a system that would satisfy their own needs. So I do not think that it mandates to them very strict regulations on how they do that.

The **Chairman**. Thank you.

We will include all of the written testimony in the record that has been submitted, in addition to those who appeared, from: Ms. Sharon Canner of the National Association of Manufacturers; Mr. Jay B. Cutler, American Psychiatric Association; Mr. Robert Dresing, Cystic Fibrosis Foundation; Sister M. Caritas Geary, the Catholic Health Association; Mr. Lou Glasse, the Older Women's League; Mr. Frederick D. Hunt, the Society of Professional Benefit Administrators; Mr. Patrick F. Killeen, International Union Social Security Department; Mr. George Pantos, Vedder, Price, Kaufman, Kahholz & Day; Mr. Bert Seidman from the AFL-CIO; Mr. Louis Sullivan, the Association of Minority Health Professions Schools; Mr. Charles W. Rogers, on behalf of Pepsico Inc. and the Employers Council on Flexible Compensation; Mr. Michael O. Routh, National Federation of Independent Business, and Mr. Mark J. Ugoretz, who is with the ERISA Industry Committee.

We will put all of those statements into the record at the conclusion of testimony to build this excellent record today as well.

The **Chairman**. Now I will turn to Senator Kennedy.

Senator **Kennedy**. Thank you very much.

I want to thank Scott Parker and the association for the excellent testimony. Mr. Parker is an enormously persuasive man, and I hope you will be able to persuade your representatives in the Senate to recognize the soundness of your position.

Let me just ask you very briefly—and we do have a shortage of time, but I think it is important that we make this record—what is the situation for hospitals across the country at the present time? I mean, people use the word "crisis". What can we expect if nothing else is done, if the funding mechanisms are not changed?

Mr. **Parker**. I think in the short term, the label "crisis" is exaggerated. In the long run, if there is no assistance with this problem, and if hospitals continue to be married to their founding principles of caring for all despite ability to pay, something has got to give. It is either going to be a deterioration of those hospitals' financial statements, or it is going to be a forced two-tier or three-tier system, something that we have not wanted in this country. And I think both of those are inevitable.

The attrition on the financial statements is going on right now. I can look at the financial statement from my own organization which would be categorized as one of the financially strong hospitals in the country, and yet over the last 5 years our bottom line has dropped considerably, simply because we have to use those revenue sources to provide for care for the increasing number of the poor among us.

Senator **Kennedy**. And that cannot continue for an unlimited period of time.

Mr. **Parker**. It cannot continue. If we cross over the lines, that means hospitals cannot continue.

Senator **Kennedy**. And I imagine that line comes at different times with various hospital systems.

Mr. **Parker**. Depending on their own history and their own reserves.

Senator **Kennedy**. But I mean, it is a general trend in hospitals all across the country.

Mr. **Parker**. Correct.

Senator **Kennedy**. And it is going to reach this kind of crisis, either in a different tier type of health care system, a reduction of quality, or I would imagine an even greater crisis for hospitals if there is no alteration or change in the current system.

Mr. **Parker**. I would agree.

Senator **Kennedy**. The proposal that we have come up with is not a magical solution. It represents at least the best judgment of a number of us here. We welcome being able to deal with the kinds of problems you have outlined, I for one. We get recommendations and suggestions about how to do it, but we are building upon some successful experiments which have taken place in various States.

There are those who say we should do nothing. I would expect, obviously, as you point out very well, that if we do nothing, we are going to be finding this kind of situation which you have outlined, and that is not a satisfactory resolution.

The question is, Is this unduly restrictive in terms of the States? We have tried, in fashioning the legislation, to provide maximum flexibility in the States in terms of the various pooling provisions, to provide resources to the hospital as an offset.

One of the principal criticisms is that it is unduly restrictive. Can you tell us what your reaction is?

Mr. **Parker**. I think until the requirements of that section of the bill are clearly defined, it is hard to respond to that, because at this point in time it is very general. You are suggesting that States be required to provide care for their poor. But there is nothing beyond that in the bill. So it is very hard to respond to the question about being too restrictive, because at this time it is very general and very ambiguous.

Senator KENNEDY. Well, we would welcome suggestions that you would have in order to meet our objective, which is to help respond to the problem that you have outlined here, and also do it in a way which provides maximum flexibility to the States. So if you have some suggestions, we would be happy to receive those.

Mr. PARKER. If you will permit us to do that, we will be happy to submit those.

Senator KENNEDY. Also you have heard today the observation that this does provide an undue burden in terms of the employers. Our information is seven-hundredths of 1 percent of payroll cost.

Do you have any comment about whether you believe that it is an undue burden to employers?

Mr. PARKER. I cannot speak for the Chamber; they have a very capable representative here. But I think they are speaking more in principle rather than in terms of specific amounts. It goes to that basic question again: Who should pay? This is a problem in search of a financial base, and everybody has been shifting it. The Federal Government is trying to shift it to the States. The States are trying to shift it to the providers or employers. Somewhere, that ball has got to stop, and it may have to rest on all of us in some kind of equitable way. I would hope, and the association would hope that that is what would come out of this legislation.

Senator KENNEDY. OK, thank you.

Mr. Maher, we welcome you to the committee. You are the director of employee benefits and health services for Chrysler Corp., is that correct?

Mr. MAHER. Yes, Senator.

Senator KENNEDY. Chrysler Corp. has a pretty extensive health insurance program.

Mr. MAHER. Yes, it certainly does.

Senator KENNEDY. It is a costly one, too. When an employee is terminated, do you provide a continuation of coverage for some period of time?

Mr. MAHER. Yes, Senator. We provide coverage for laid-off individuals for a period considerably greater than is set forth in this bill.

Senator KENNEDY. Do the employees feel that this is a valuable program?

Mr. MAHER. Obviously so, Senator.

Senator KENNEDY. Do you think it is a valuable benefit to the employees?

Mr. MAHER. Certainly.

Senator KENNEDY. One of the things that has always impressed me is the concern that Chrysler and others in the automobile industry have talked about the cost shifts in health insurance, that they provide good benefits to their employees, and yet they are required to pay a part of those that are not being covered. Are you aware of that observation that has been made by, I think, Chrysler as well as others in the automobile industry?

Mr. **Maher**. I think to a certain extent we very much share the views stated in the Chamber's testimony here this morning, that Chrysler certainly does not object in any way to paying its fair share of the cost of any societal problem. What we oppose is having our health care bills serve as being a tax base for the levying of a surcharge to subsidize coverage for others.

Senator **Kennedy**. Well, one of the burdens in terms of the cost-shift for charity which, as I understood, the company itself and other companies are concerned about, was the unreimbursed care for unemployed workers and their families who do not get extended health insurance coverage from their employers.

Mr. **Maher**. Yes. I think we would oppose looking solely to existing health care billpayers to raise a pot of money to fund health care coverage for employees of companies who have elected not to offer coverage; and when you go to pass the hat, you bypass those employers who are failing to offer coverage. It is innately unfair, it seems to me.

Senator **Kennedy**. Well, how would you address it, then?

Mr. **Maher**. I think you have to spread the cost across society in the broadest sense. For example, if you were to use general tax revenues or payroll tax revenues—I am speaking now for Chrysler, not as a spokesman for the Chamber—that would spread the cost fairly around society, as opposed to simply taxing the bill payments of companies that are already paying for health coverage, because in my sense, my company would have the highest conceivable base, because we cover employees, dependents, laid-off people, retirees, and that greater pot of money would serve as our tax base.

Senator **Kennedy**. I was just checking with staff, because I do not see anything in that legislation that would require Chrysler to pay a nickel.

Mr. **Maher**. To the extent that the revenue base for the subsidy for the State insurance pools were the payments of health care billpayers——

Senator **Kennedy**. But that is a question for the States, isn't it? I mean, that would be a question that you would have to work out in terms of the States.

Mr. **Maher**. That appears to be the direction—again, as I read the bill—that appears to be the direction that the States are pointed toward.

Senator **Kennedy**. Would you support it if it was among all employers in the State, if the risk was among all the employers of the State?

Mr. **Maher**. If that represented a fair spreading of the cost. In other words, I do not want to answer that question in a vacuum—and again, I am speaking in my own company's behalf. We would want to make certain that the social cost was being spread fairly, and if we were convinced of that, we would certainly support it because we believe that the country would be better served by having universal access to health care.

Senator **Kennedy**. I would be glad to have you take a look at it and get back to us. I am just trying to elicit a thoughtful response on it.

Mr. **Maher**. Sure.

Senator **Kennedy**. Let me submit a couple questions along that line. I would be interested in both your response, as well as the chamber's, and the distinction, if I could.

Mr. **Maher**. Sure, Senator.

Senator **Kennedy**. Mr. Parker?

Mr. **Parker**. Senator, one approach that gets to this problem—and it is a very real one—might be for the State to develop some kind of stop-loss program, some kind of reinsurance based on the State's tax base, to give the corporations who stand at risk some predictability of what that risk would be, and limit it.

Senator **Kennedy**. I see. That is a very interesting idea and a constructive one.

Ms. Santilli, we appreciate your comments. I do not know whether you would like to make some comment on this general subject matter.

Ms. **Santilli**. Well, the coalition does not have any strong feelings about how the money is collected. I think the one thing that we realize is that the amount of assessment would be very low. You are talking about 1 percent. And people have to pay one way or another; whether you are paying in taxes for other social programs, you are paying some way.

Senator **Kennedy**. Well, I think that that is correct. The approach that we are taking—as someone who has been involved in the health issue over a long period of time, there is a good deal of whipsawing. If we do a comprehensive program, it is too comprehensive; if you do it in increments, it is too partial. These are the kinds of arguments that we made, and in the meantime, the total numbers of people who are not covered increase, and we are facing the types of crises that have been described by Mr. Parker.

That is the dilemma we are faced with, and meanwhile, there are millions of Americans who are at risk and whose health is really threatened, and we are going to certainly do what we can to try and respond to what is a very important problem today and what has been described by those in my own State, those in Philadelphia and Pittsburgh, those in Utah and across this country are facing and will face in an even more dramatic and adverse way unless we are able to work out an adequate response.

So I want to thank all of you very much for joining us today. It has been informative to me, as always, and I appreciate your testimony.

Thank you.

[Additional statements submitted for the record follow:]

Statement of
the National Association of Manufacturers
on Access to Health Care, (S. 2402/2403)
Before the Committee on Labor and Human Resources
July 16, 1986

Mr. Chairman and members of the Committee on Labor and Human Resources, we are pleased to submit this statement on behalf of the National Association of Manufacturers. The NAM is an organization of over 13,500 corporations of every size and industrial classification located in every state. Members range in size from the very large to over 9,000 smaller manufacturing firms, each with an employee base of less than 500. The NAM is also affiliated with the National Industry Council which includes 135 state and local business associations representing 138,000 individual companies.

The following statement, submitted in response to the Committee's hearing on barriers to health care, will focus its attention on the "Access to Health Care Act" (S. 2402/S. 2403) referred to the Committees on Labor and Human Resources and Finance.

Mr. Chairman, we share your concerns with the problems of care for the medically indigent and the barriers that some individuals incur in gaining access to care. Indeed, the NAM encourages its members to voluntarily provide various types of assistance as proposed under S. 2402/S.2403. However, certain provisions of the "Access to Health Care Act of 1986," would interfere with state and local programs now in place and further discourage the expansion of employment-based health insurance, the source of protection for over 85% of American workers and their families. Therefore, we cannot support this legislation.

We believe health care for the poor and the uninsured is a multi-faceted problem demanding a variety of creative, thoughtful and fiscally responsible approaches. Various initiatives responding to this problem are already underway. For example, many employers voluntarily extend health insurance coverage to laid-off workers and their families, and some 34 states operate indigent care programs, while in the remaining states, most counties and municipalities have some legal responsibility for providing medical care to residents. Options, including existing regulatory authority, have been used by some to assure that institutional providers furnish care to indigents. Georgia for example, requires parties purchasing or leasing a public hospital to provide an amount of charity care equal to three percent of hospital gross revenues for the sale or lease to be approved. State and local programs are designed to reflect local needs of the respective populations.

In particular we call your attention to the following troublesome provisions:

Establishment of Statewide Insurance Pools. Under the proposal, all states would be required to form insurance pools for persons not covered by job-based insurance and for persons unable to secure coverage for other reasons. Both group insured and self-insured employers, who do not participate in the pool by covering its losses, would be subject to a 10% civil penalty levied on the amount that employer expends on health insurance.

The problems with this proposal are many. First, pool losses could be considerable since participants are likely to be those at highest risk and with the least incentive to make cost-effective use of health services; thus employers, particularly smaller ones and those in poor financial condition, would be reluctant to participate. The threat of a 10% penalty may cause employers to have lesser resources available for payment of basic wages, or might even force them to reduce the level of health benefits they do provide.

Second, pools are not appropriate for every state, as mandated federal standards fail to recognize the uniqueness of medical costs or benefit design issues relative to a particular area. Mandated state pools would also require new bureaucracies to administer the program---surely a costly undertaking for states.

Finally, since employers would have to pay for costs not covered by premiums---and costs are likely to be enormously high---the expense to the employer community will be great. It would thus be a further disincentive for employers to offer health insurance benefits to their workers in order to avoid paying into the risk pool for the employees of their competitors who do not provide benefits. Some employers may decide to forego offering health benefits altogether.

Nine states now offer risk pools. Major insurers in most of these states are assessed the difference between the premium income and expenses of the pool, allowing them to claim this amount as a tax deduction. Generally, states do not subsidize the pool, since these costs can be quite high due to the high risk groups participating. Similarly, asking employers generally to subsidize the losses, could also be extremely costly, seriously impacting their economic viability in some cases.

State Programs for Payment of Uncompensated and Charity Care. Under S. 2402/S.2403, all states would be required to develop and implement a mechanism for subsidizing uncompensated and charity care. Failure to comply would result in loss of Medicaid administratve funds.

A variety of financing mechanisms--sales taxes, cigarette taxes, general revenues, property taxes, and assessments on provider revenues--are being used by states to fund indigent care programs. A 1985 survey of states conducted by the National Governor's Association and the Intergovernmental Health Policy Project shows that the problem of indigent care is being addressed by revising the eligibility criteria for existing programs in order to reach those who do not have access to services. Rather than across the board expansions in the Medicaid area, for example, states are carefully targeting their resources to most efficiently allocate scarce resources. Young children and pregnant women are key groups because of the high benefit/cost ratio and also because of the concerns over increased infant mortality rates.

Although these programs vary in their scope and breadth of coverage, many innovations are in process and should be encouraged. It is inadvisable to mandate federal legislation before fully testing and assessing the effectiveness of existing programs. Strengthening these efforts does not require new federal legislation and, indeed such efforts could be harmed by such interference.

On the hospital side, hospital patient revenues increased 6.9 percent between 1983 and 1984, while hospital total net margin was 5.1 percent in 1984, compared to 4.2 percent in 1983, according to data reported by the American Hospital

Association. Understandably, certain regions may experience higher indigent care loads and it is tempting to look for quick-fix solutions. Overall, these data do not show that the costs of indigent care have adversely impacted hospital revenues generally and federally mandated subsidization of hospital costs appears to be unwarranted at this time. Further, experience to date with the prospective payment system has not demonstrated a financially adverse inpact on hospitals.

Extension of Employment-based Health Insurance for Laid-Off Workers. This provision requires employers to cover the cost of four months of health insurance for laid-off workers (also terminated) and their dependents. An open enrollment period for employed spouses of workers who lost their jobs and their health insurance is also included. Both employer and employee would continue to pay whatever share of the premium they paid before lay-off.

After four months, laid-off workers would continue this coverage for 18 months at their own expense, but at group rates, pursuant to Title X of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), signed into law just a few short months ago and effective July 1, 1986. (Relative to Title X we have attached a letter transmitted to the Department of Labor outlining our concerns. The letter points out current issues which should be resolved before creating an additional new mandate.)

Only minimal guidance from the Department of Labor has been issued to assist employers in complying with this new law. The proposed bill is legislative overkill and a duplicative, confusing, and complex burden on employers who provide health care coverage to their workers.

While many companies provide varying degrees of coverge to laid-off employees, mandated company-paid health insurance will place undue hardships on small businesses. Small businesses, roughly defined as those with under 100 employees, are the greatest source of job creation in this country. A recent Bureau of Labor Statistics study reported that between 1970 and 1984, which included two recessionary periods, small business was responsible for 26 million new jobs. Legislation should not place unnecessary obstacles in the path of small business development.

This provision will also have an adverse impact on plant closures. In costing out closing a plant, companies must assess their financial viability in terms of resources they can allocate to severance pay, out-placement and job search, retraining, and employee benefits. Forcing greater allocations for health insurance will mean decreasing an employer's flexibility in assisting former workers in securing new employment or with severance pay.

The issue of job lay-off and health insurance has been a frequent subject for the Congress. In 1983, House and Senate Committees considered bills similar to S. 2402\ S.2403. At that time, the NAM went on record supporting limited employer-paid health insurance given the existing economic conditions.

This legislative position was in response to the 1982 recession, the worst year for unemployment since World War II. Even then however, the average spell of unemployment lasted just over three months and two out of every five spells of unemployment lasted for less than one month. Data for that period show that health benefits were widely available as witness a 1983 Business Roundtable survey of its member companies which showed that seventy-two percent of respondents extended total benefits for an average of eight months. Another nine percent of firms extended partial coverage to laid-off employees for an average of about seven months. Respondents represented more than 1800 companies with 800 plant locations employing more than 500 employees. We have reason to believe that coverage has remained the same or improved since that time.

Today, the economy is growing and retraining is helping many laid-off workers to secure new jobs, and with that, access to employment-based group health insurance. Those lacking health insurance, are, as of July 1, permitted to purchase insurance at group rates for a period of 18 months as authorized under Title X of PL 99-272. For others, participation in a working spouse's health plan is an option.

Mandated extension of employer-paid health insurance as proposed would be a duplicative and onerous burden on employers and we strongly oppose such legislation.

We do support the following two provisions:

Tax Incentives for the Self-Employed. S. 2403 would permit self-employed individuals to take the business tax deduction for the cost of the lowest premium they pay for health insurance for their full-time employees. Such incentives would do much to encourage health insurance coverage to those working for unincorporated businesses. The Senate tax bill wisely includes a similar proposal and we support that particular provision.

Demonstrations on Cost-Effective Insurance for Small Firms. S. 2402/2403 require the Secretary of the Department of Health and Human Services to conduct studies and demonstration projects on ways to lower the cost of health coverage for small businesses. We support this provision as a way to highlight promising models that have assisted smaller companies to better manage their health costs.

A number of innovative approaches, including that operated by Cleveland's Council on Smaller Enterprises, are demonstrating that reasonably priced group health insurance is being provided by smaller companies. In Cleveland, some 4,500 member companies, 40 percent of which have less than 10 employees, enjoy group health coverge through a centralized system of enrollment, service and marketing. Nearly 45,000 employees and their dependents are covered by the plan. In 1985, major program costs remained the same or declined, a major feat for companies usually at a disadvantage in obtaining cost-effective insurance contracts.

Other activities meriting study are the more than 150 business/health coalitions existing in 45 states whose aim is the management of health costs through the collective action of employers working together.

CONCLUSION

Health care for the medically indigent and the barriers that some individuals incur in obtaining access to care are problems shared by both private and public sectors, and we are pleased to work with you in seeking constructive and responsible solutions. In February of this year, the NAM Board of Directors called attention to this issue by urging member companies to: (1) make available on a temporary basis health insurance coverage to laid-off workers and their families; (2) assist in the development of group insurance purchasing by coalitions and state associations to help smaller firms; (3) support selected expansion of Medicaid; and (4) encourage the use of managed systems of care in health programs for indigents.

We believe the first three provisions of H.R. S. 2402/S.2403, as noted above, are not appropriate solutions to the problems of the medically indigent. Rather, statewide insurance pools, hospital programs to finance uncompensated and charity care, and employer-paid health insurance for laid-off workers are already more appropriately being addressed within the context of existing state laws and agreements between management and labor. NAM does support tax incentives for the self-employed (in S. 2403) and demonstrations on cost-effective group insurance for small firms as positive steps to dealing with this complex problem.

We hope the above comments on S. 2402/S.2403, will be helpful in your deliberations on the issue.

# # #

Employee Benefits Committee

HEALTH CARE SUBCOMMITTEE

Financing Medically Indigent Care

A Policy Statement

NAM Board of Directors

February, 1986

Background

The number of individuals unable to pay for medical care is a growing problem which has major implications for employer health care costs. In the past, payment for the medically indigent was generally built into rates that hospitals charged to private sector payers. This practice of cross-subsidization, or cost shifting, is fast becoming less well hidden given the implementation of prospective payment and diagnosis-related groups (DRGs) for Medicare patients;all payor legislation in some states; the development of a more competitive hospital product; and the growing savvy of employers in making prudent purchasing decisions on behalf of their covered workforce.

Ultimately, the costs are paid by consumers and/or tax payers and this includes corporations. As such it is important to openly acknowledge the costs rather than conceal them, and seek solutions which recognize the appropriate roles and responsibilities of government and the private sector. It is also important to note that much of the care falls disproportionately on hospitals with high percentages of beds dedicated to obstetrics, neonatal intensive care, burn care, as well as to emergency/outpatient departments particularly of larger institutions in metropolitan areas.

The steps in working toward the goal of meeting indigent care needs include openly identifying the individuals to be categorized as medically indigent, identifying appropriate and available sources of funding, and matching the particular category of indigent with the appropriate funding source. In addition, solutions to the problem should be cost effective; encourage innovation and competition; promote local alternatives as opposed to federal approaches; educate beneficiaries to be better consumers of health care; assure quality care; be administratively simple; politically realistic and above all, affordable.

Policy Recommendations

To address the needs of the medically indigent, the NAM urges member companies to:

(1) Encourage the use of managed systems of care in programs for indigents. Included are preferred provider arrangements, capitated approaches including HMOs, competitive bidding arrangements, and similar cost effective mechanisms.

(2) Support selected expansion of Medicaid with particular attention to target groups and services such as prenatal and wellbaby care, pediatric care and other selected preventive services.

(3) Support incentives to encourage more employers to make available on a temporary basis health insurance coverage to laid-off workers and their families. The aim of this assistance is to encourage individuals to seek work promptly.

(4) Support voluntary dependent coverage on a temporary basis through group health plans. Employers should be encouraged to make available coverage to widows, divorced spouses, and dependent children on an interim basis. Individuals should pursue other means of coverage to adjust to their changed circumstances.

(5) Encourage the development of group insurance purchasing, such as by coalitions and state associations of manufacturers, for purposes of assisting small businesses to provide adequate insurance for their employees in a cost effective way.

(6) Encourage the establishment of state catastrophic health insurance programs to assist those who have exhausted all available third party benefits.

(7) Encourage the establishment of state risk-sharing pools for persons unable to obtain insurance because of high-risk illnesses; provide incentives, such as tax credits.

NAM
National Association
of Manufacturers

Industrial Relations Department

June 4, 1986

David M. Walker
Deputy Assistant Secretary
Pensions and Welfare Benefit Administration
U.S. Department of Labor
Room N5677
200 Constitution Avenue, N.W.
Washington, D.C. 20201

Dear David:

Beginning on July 1st, Title X of PL 99-272 (Consolidated Omnibus Budget Reconciliation Act) requires employers to make available continuation health insurance coverage to separated and divorced spouses, dependents and those who have lost coverage due to job lay-off.

This mandate raises numerous administrative questions for employers. The following is a list of questions which we would like to see addressed by regulations being prepared by the Department.

Continuation Coverage

1. Are ancillary employer health plans (e.g., dental, vision, prescription drug, hearing) affected by COBRA?

2. Does the term "as of the time the coverage is being provided" mean "at the time the person is enrolled"?

3. Must individuals who have elected continuation coverage be permitted to move among health plan options (e.g., high-low, HMO open enrollments)?

4. May health plan design changes be extended to individuals who have exercised continuation rights?

5. How does the continuation requirement apply to HMOs?

6. How do the continuation requirements apply to health benefits offered through a cafeteria plan under IRC S 125?

1776 F Street, N.W.
Washington, D.C. 20006
(202)637-3000

Notice Requirements

7. Since the required election period must last at least 60 days after the date a qualified beneficary receives the required notice, will employers have to keep copies of notice requirements for up to 20 (in some cases 38) months as proof that notice was given?

8. Is there any time limit on when a covered employee or qualified beneficiary must notify the plan administrator of the occurrence of a divorce, a legal separation or, a dependent child ceasing to be a eligible under the plan?

Coverage

9. May continuation coverage be terminated by an employer when an individual becomes eligible for coverage under another employer's health plan?

10. Can children who cease to be dependents be charged individual (as opposed to dependent) premium?

11. If a qualified beneficiary remarries but does not thereby become covered under another group health plan, must we continue to cover him/her? I assume we need not cover his or her dependents at that point -- is that an accurate assumption? What if they are then eligible for other coverage -- again does "covered" mean "eligible for" or "enrolled"?

12. Does it apply to retirees who have medical coverage and get divorced?

State Laws

13. How will state law continuation requirements relate to the federal continuation requirement?

Qualified Beneficiary

14. Are retiring employees eligible for continuation?

Conversion

15. Must employers arrange for a conversion policy to be available to individuals when their continuation period runs out?

Premiums

16. May individuals opting for continuation coverage be rated as a separate class?

17. Why is the GNP deflator (rather than a more relevant indicator such as the medical care component of CPI) prescribed for automatically adjusting plan cost for self-insured plans?

Finally, can you give us an indication of the time frame for publishing regulations or other guidelines on Title X? To address these issues in further depth, we would be pleased to arrange a meeting of our members with your office. Thank you for this opportunity to provide input on these important regulations.

Sincerely,

Sharon

Sharon F. Canner

SFC:yab

American Psychiatric Association

1400 K Street, N.W., Washington, D.C. 20005 · Telephone: (202) 682-6000

STATEMENT OF THE

AMERICAN PSYCHIATRIC ASSOCIATION

REGARDING

BARRIERS TO HEALTH CARE

SENATE LABOR AND HUMAN RESOURCES
COMMITTEE

JUNE 16, 1986

The American Psychiatric Association, a medical specialty society representing over 32,000 physicians nationwide, is pleased to submit testimony regarding barriers to health care. Because of the stigma associated with mental illness, as well as the poor coverage for the treatment of mental and addictive disorders, individuals are often prevented from receiving needed care.

Our testimony focuses on the cost-effectiveness of mental health care, the extent of need for mental health care in the population; and our suggestions for methods of incorporating psychiatric services into any catastrophic proposal.

Mental Illness and Addictive Disorders

According to the Institute of Medicine (IOM) report "Research on Mental and Addictive Disorders", 15% of the population suffers from serious mental disorders at any one time, but less than one third of these people will receive any treatment. Here we wish to emphasize that we are speaking of a disease -- mental illness -- not the health/happiness/achievement of potential/social welfare continuum. Treatments for mental illness may be as aggressive as many life saving techniques.

In the elderly population, health problems are often more complex than those of other age groups. The elderly population is growing and will represent a larger proportion of the population, approximately one in five persons in the next thirty years. Many elderly people have more than one health problem and may need more than one type of health care provider. Estimates indicate that some 15 to 20 percent -- between 3 and 5 million -- of our nation's more than 25 million older persons have significant mental health problems, yet they are denied adequate treatment because of the discriminatory "caps" imposed on psychiatric treatment under Medicare. Under the current Medicare system, outpatient benefits are restricted to $250 per year after coinsurance and deductibles, and this amount has not been increased since the Medicare program's inception in 1965. Statistical estimates also indicate that twenty to thirty percent of older Americans who have been labeled "senile" actually have reversible, treatable conditions. If adequate mental health coverage were provided, these beneficiaries could become productive, active members of society, and avoid unnecessary and costly hospitalization. Coverage of the mental health needs of these elderly people under Medicare could provide the mentally ill elderly the dignity, productivity, and independent living which are the keystones of the Older Americans Act of 1965.

Clearly there are instances where the compelling limitation on outpatient psychiatric care forces use of more expensive inpatient care, and adds avoidable expenditures to an already strapped Medicare program. In fact, the offset effect -- a reduction in health care utilization when mental health services are provided -- has been documented in many studies. For example, researchers have demonstrated decreases in inpatient utilization when outpatient mental health benefits are offered. A meta-analysis of (reanalysis of multiple studies) 58 controlled studies, and an analysis of the Blue Cross and Blue Shield Federal Employees Plan claims for 1974-1978 found the cost-offset effects of outpatient mental health treatment resulted primarily from reductions in inpatient utilization. The offset effect was greater for individuals aged 55 and over.

One recent NIMH study of Aetna Life Insurance Company's claims for enrollees in the Federal Employee Health Benefits Program compared overall health care service use by families which did and did not use outpatient mental health services from 1980 to 1983. Prior to the initiation of mental health treatment, use of overall health services rose gradually for three years with a sharp increase during the six months immediately preceding mental health treatment. Once mental health treatment was initiated, overall health use fell, and the greatest decrease in health utlization occurred for persons over age 65. Overall, general health use cost $493 per month for the six months just prior to initiating mental health treatment and $137 per month three years after treatment. The additional cost of mental health treatment was $13.96 per individual covered by the plan. The authors of the Aetna study caution that interpretation of other data over short periods of time may mask the dramatic nature of changes in health care service utilization after mental health treatment commences. Other studies have also demonstrated a decrease in hospital treatment after use of mental health services and one review of the literature found a 20 percent reduction in health care costs associated with mental health treatment. These results suggest that the Medicare populati[illegible] been denied the mental health treatments it needed, and potential significant cost savings have been lost.

The costs and benefits of liaison psychiatry have also been documented in the literature. All the components of these services -- for instance, discussions with family and staff -- are not fully reimbursed under Medicare or private insurance programs. A controlled study examined clinical outcomes of a group of elderly patients (age 65 and over) who underwent orthopedic surgery for fractured femurs. Those receiving liaison psychiatric services stayed in the hospital 12 days less than patients who did not receive such services. (A several thousand dollar cost saving by any measuring device). The treatment group was also twice as likely to be discharged home instead of to a nursing home or other health-related institution. Thus, liaison psychiatry services provided clear cost savings by reducing health care utilization in other portions of the health sector.

We all know elderly people, and we watch as they lose close friends, relatives, and meaningful work. These assaults on their self-esteem are likely to put people at significant emotional risk. For instance, in 1982, the population over age 65 accounted for just over 10% of the U.S. population, but 17% of deaths by suicide. Also estimates indicate that people over age 65 receive as much as half of the prescribed barbituates and sedatives. This drug therapy is not always prescribed by the psychiatrist.

The psychiatrist is uniquely trained to treat the patient who requires both pharmacotherapy and psychotherapy, an increasingly frequent therapeutic prescription in an era of advancing understanding of complex biopsychosocial components of mental illness. This is an especially important point on which we would like to elaborate. Within the past few years, exciting new breakthroughs in the treatment of mental disorders have significantly changed not only our understanding of the causes of mental disorders; but have also given us the ability to treat such disorders more effectively. For example, through recent research we have attained the capacity to effectively treat more than 85% of all severe depressions using drugs and psychotherapies; we have verified the existence of a genetic component to the psychoses, and determined that environmental events may trigger one's inherited risk or predisposition for a given disorder; we have refined techniques for diagnosing mental illness, which permits treatments to be tailored specifically to a patient's needs and ensures comparability of results in clinical research; we have gained a capacity, through techniques such as positron emission tomography and nuclear magnetic resonance, to observe biochemical activity in the conscious brain and define discrete areas of the brain that may be defective in certain illnesses. Finally, we have developed pharmacologic and behavioral treatments that are effective in treating phobias and other anxiety disorders, demonstrated that memory loss and other cognitive deficits associated with Alzheimer's Disease may be modifiable with medication, and improved methods for assessing the effectiveness of psychotherapy and for identifying specific types of psychotherapies best suited to specific disorders. An impressive, but not even an exhaustive list. Medicare coverage policy prevents the elderly from receiving the benefits of these breakthroughs.

Additionally, psychiatric symptoms are frequently non-specific and commonly occur in medical, as well as psychiatric disease. There is evidence indicating that having a psychiatric diagnosis is associated with a high risk of medical illness. Also, there are a great many physical illnesses that, upon initial presentation, appear to be nervous and mental disorders.

The research literature fully documents psychiatric illness produced by infections, thyroid gland dysfunction, chronic encephalopathy related to heart block, carcinoma of the pancreas, hyper-parathyroidism, Wilson's disease, sub-acute encephalitis, and strokes.

These studies also emphasize the importance of the interrelationship between specific psychiatric symptoms and specific medical diseases. Physicians in practice must continually weigh such psychological factors as personality traits to properly treat rheumatoid arthritis, hypertension, peptic ulcer, diabetes, ulcerative colitis, allergic skin infection, bronchial asthma, coronary disease and cancer.

Despite these many mental health needs, the elderly population receives only 6 percent of community mental health services and 2 percent of private psychiatric services. Medicare mental health coverage policy has discouraged our Medicare patients from seeking psychiatric care. Most researchers agree that the mental health needs of the Medicare population are underserved, and disagree only on the extent of underservice. The recent Harvard Medicare report recommends that coverage of mental health services be expanded. As the report noted, the omission of adequate coverage for mental health care (as well as long-term care, home health care and nursing home care) places older Americans at risk for significant expenditures. Studies have also indicated that in the population as a whole between one-third and one-fifth of individuals identified as having a mental disorder during a six month period used any mental health service from either mental health specialists or general medical physicians. The lack of utilization of mental health services is due to both poor coverage policy and the stigma associated with mental disorders.

As mentioned previously, despite the extensive prevalence of mental disorders, fewer than one-fifth of individuals with mental illness seek care. This may be due to the stigma associated with mental illness as well as problems with insurance coverage. APA's own survey of 300 insurance plans (published in 1983) indicated that although all plans had some level of coverage (inpatient and/or outpatient) for mental illness, only 6% of plans had outpatient and inpatient coverage for mental illness comparable to that for physical illness. Thus, both employed, unemployed, and the elderly are likely to have coverage problems for mental and addictive disorders and coverage for catastrophic expenditures on mental health services becomes even more critical than with physical illness.

Conclusion

As you deliberate the many issues associated with barriers to health care, we hope that you will carefully consider the mental health needs of all populations. In addition, it would be very important that if states establish risk pools, they also be encouraged to maintain parity for mental and general illness coverage in all plans. Often mental health services are not made available unless required. In addition, for employed individuals who cannot obtain health insurance through employers due to preexisting conditions, why not have employers contribute to the risk pool the amount they would normally have paid for the health insurance for that employee?

Cystic Fibrosis Foundation
National Office
(301) 881-9130
6000 Executive Boulevard • Rockville, Maryland 20852

July 14, 1986

The Honorable Orrin G. Hatch
United States Senate
Washington, D.C. 20510

Dear Chairman Hatch:

I am writing to you on behalf of the Cystic Fibrosis Foundation regarding the pooled risk health insurance provisions of Section 2 of "Access to Health Care Act of 1986," S-2402, which is pending before the Senate Labor and Human Resources Committee.

The Cystic Fibrosis Foundation would like to submit to the record its statment on the pooled risk provisions of the bill. These provisions are critical in the effort to change current insurance practices so that our families will have the opportunity to buy health insurance protection. As soon as the results are tabulated, the Cystic Fibrosis Foundation will be providing you with a copy of our survey of CF families documenting the need for pooled risk health insurance.

We urge you to support the pooled risk health insurance provisions of S-2402, and appreciate the opportunity to add our testimony to the record. Thank you for your consideration.

Sincerely,

Robert K. Dresing
President and Chief Executive Officer
Cystic Fibrosis Foundation

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Statement of the Cystic Fibrosis Foundation to the
Labor and Human Resources Committee
United States Senate
regarding the
Pooled Risk Health Insurance Provisions of S-2402

Each year, medical care for the 30,000 children and young adults with cystic fibrosis (CF) costs $300 million. The families of these children and young adults, willing to pay for health insurance, face a most heartless type of discrimination. Their children are classified by health insurance companies as having a "pre-existing condition," making it difficult to buy insurance for the reason they need it most -- to cover costly CF medical care. Even when families do find an insurance plan that will accept them, they frequently must pay exorbitant fees and wait a year before the medical care is covered. Others forego essential medical care or face financial problems because they cannot pay their medical bills. The Cystic Fibrosis Foundation is currently compiling the results of a survey on these insurance problems among its families, to be provided to the Committee upon completion.

The pooled risk health insurance provisions in S-2402 provide a solution to these problems by providing incentives for states to set up risk pooling plans and by removing barriers that prevent state plans from being effective. No federal funds are required, and purchasers will pay into an insurance pool like any other group coverage plan. Modeled after successful programs in a number of states, the pools would be regulated like other state insurance.

The Cystic Fibrosis Foundation urges the Committee to support the risk pooling provisions in Section 2 of S-2402. Excluding people with illnesses like CF from buying health insurance is contrary to the very notion of health insurance protection. The Foundation asks the Committee to give these families the chance for reasonable coverage of their medical needs and to close the unfair gap in our country's health insurance system.

The Catholic Health Association
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STATEMENT OF

THE CATHOLIC HEALTH ASSOCIATION
OF THE UNITED STATES

on the

ACCESS TO HEALTH CARE ACT OF 1986
S 2402

before the

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

presented by

SISTER M. CARITAS GEARY, SP
CHAIR, CHA TASK FORCE ON HEALTH CARE OF THE POOR
and
PRESIDENT, MERCY HOSPITAL
SPRINGFIELD, MASSACHUSETTS

July 16, 1986

I am Sister Caritas Geary, SP, President, Mercy Hospital, Springfield, Massachusetts.

On behalf of The Catholic Health Association of the United States (CHA), whose membership includes over 900 hospitals and long-term care facilities nationwide, I am grateful for the opportunity to express CHA's strong support for the Access to Health Care Act of 1986 (S 2402), sponsored by Senator Edward Kennedy. It is truly an encouraging sign to see such congressional leadership in addressing the alarming growth of medical indigence in the United States. Our country correctly believes that it has the premier health care delivery system in the world. Nevertheless, the fact that nearly 37 million Americans still do not have access to adequate or necessary health care raises fundamental questions about the system's integrity from the point of view of justice.

During the past year I had the distinct honor of chairing a select CHA task force on the needs of our nation's health care poor. In April, our Board of Trustees adopted a report from the task force entitled, NO ROOM ROOM IN THE MARKETPLACE: THE HEALTH CARE OF THE POOR. Over a year in the making, the report contains a series of recommendations aimed at challenging Catholic health care institutions, the Catholic Church in the United States and federal and state governments to better ensure health care services for the poor and those without health insurance or sufficient health insurance. We have provided each member of the Committee with a copy of the report and have submitted a copy for inclusion in the record of these proceedings.

Several factors explain why ensuring the availability of health care services for the poor has become such an urgent concern. A marketplace environment, driven by competition among health care providers, requires that persons pay for the services they need. In such an environment there are few, if any, economic incentives to provide care for those unable to pay. Because many poor persons lack either public or private health insurance, and many more are underinsured, their access to health care services is seriously diminished.

The current preoccupation with controlling health care costs is, therefore, causing our nation to renege on its longstanding commitment to provide for the health care needs of the less fortunate in our society. This commitment is premised in justice, not charity. In short, the health care poor are one of the principal casualities in our nation's current deficit reduction battle.

The Catholic Health Association continues to believe that universal health insurance remains the superior method of insuring access to health care for all. However, until that ideal becomes more politically achievable, CHA strongly supports interim legislative initiatives, such as S 2402 and its companion bill, S 2403, sponsored by Senator David Durenberger. In particular, four of the five key elements contained in S 2402 are similar to recommendations proposed by the CHA Task Force on Health Care of the Poor:

- Both seek an extension of employment-based health insurance coverage for laid-off workers and their dependents.

- Both seek the establishment of subsidized health insurance pools to allow persons without access to employment-based coverage to buy individual health insurance regardless of their health history.
- Both would require states to establish a mechanism to fund hospital charity and unreimbursed care.
- Both would change the tax laws to encourage more employers to provide health insurance to their employees and employees' dependents.

Encouraged by congressional initiatives and challenged by the recommendations issued by the CHA report to our own institutions, The Catholic Health Association is desirous of working with Senator Kennedy and the other sponsors and with like-minded groups and associations to ameliorate the problems facing our nation's health care poor. S 2402 is an important and necessary step in that direction. We commend Senator Kennedy for introducing the legislation and pledge our support for the bill's enactment.

Older Women's League
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STATEMENT OF THE OLDER WOMEN'S LEAGUE

on

BARRIERS TO HEALTH CARE

presented to the

SENATE LABOR AND HUMAN RESOURCES COMMITTEE

July 16, 1986

Senator Hatch, members of the Committee. The Older Women's League appreciates this opportunity to share with you our concerns about barriers to health care.

Founded in 1980, OWL has 20,000 members and chartered chapters in 35 states. Through education, research and advocacy, we work for public policy changes to reduce the inequities women face as they age. Among their greatest concerns is access to affordable health care.

The Older Women's League appreciates this opportunity to share those concerns with the Committee. We commend you for focusing on barriers to health care, most especially the lack of either private or public health coverage among millions of Americans. OWL believes that the provisions of the "Access to Health Care Act of 1986" (S. 2402) will reduce the number of uninsured individuals by making it easier for them to get private health coverage. Such improvements will be gladly welcomed by millions of midlife women who are now uninsured.

While estimates of the uninsured range from 20 million to 37 million, by any count a majority of Americans under age 65 have some health insurance, most through private plans. About 85% of private coverage is group coverage, and most of that is through employment. As long as individuals are in covered employment or related to employed workers, they have health insurance. A change of work or family status, however, too often means a loss of health insurance. And in today's medical economy, the lack of health plan coverage is a formidable barrier to health care.

While both men and women lose health coverage when unemployed or laid-off, women also lose coverage when they are widowed, divorced, or their husbands retire. Thus, health coverage for women is highly dependent on both marital and work status. Here are some examples of that interrelationship:

- Mary H. and her teenage sons lost health insurance when her husband died at age 56; she has been a homemaker for many years, and is having great difficulty in finding a job.
- Sylvia J. lost coverage at the time of divorce; her children were continued as dependents in their father's group plan at work, but she was dropped. She works full-time as a secretary in a small firm that does not have employee health insurance.
- Barbara B.'s husband retired under pressure from his employer when he turned 65. He is eligible for Medicare, but at 62, she won't be eligible for three more years. She retired from longtime employment after a mastectomy at age 60; because of her health history, she has not been able to find any affordable health insurance policy.

These are by no means isolated examples. About 5 million women between the ages of 40 and 65 have no health coverage, no protection against the costs of catastrophic illness, and limited access to any health care. Women are more likely than men to be "medically dependent" because of lower labor force participation rates, and higher rates of employment in part-time or low-wage service jobs without health benefits.

Most married women, whether in the paid labor force or not, have private health insurance. But only about half of widows and a third of divorced women not in the labor force have such insurance; among women under age 65, 40% of divorced women and 25% of widows not in the labor force depend on Medicaid.[1]

Midlife women are not only more likely to be without health coverage than men of the same age, they are also at greater risk than younger persons. While health coverage is lowest among persons ages 18-25 (due to student status or unemployment after losing coverage under a parent's plan or Medicaid), young adults are less likely to need hospital care.[2]

The Older Women's League identified access to affordable health insurance as a crucial health problem for midlife women. We developed a model state bill requiring group health insurance continuation for medically-dependent spouses, and advocated its passage in more than a dozen states. From 1981 to 1985, bills based on the model were enacted in seven states (Illinois, Kansas, Louisiana, Missouri, Oregon, Texas, and Vermont).

Mr. Chairman, as you know, federal legislation addressing the issue of spousal health insurance continuation was first introduced in Congress in 1985. (Bills included: S. 1211, Sen. David Durenberger: S. 1615, Sen. Edward Kennedy; S. 1632, Sen. John Heinz; and H.R. 21, Reps. Pete Stark and Bill Clay).

With your support, provisions from these bills were included in the 1985 budget reconciliation bill, signed into law April 7, 1986 as Public Law 99-272. Once fully implemented, Title X of PL 99-272 will protect many Americans against a sudden loss of coverage at a vulnerable time--when they are unemployed, divorced, widowed, or their spouses retire.

Since the law begins to take effect on July 1, the Older Women's League has undertaken a public information campaign on the new law. We've produced a consumer information pamphlet to answer questions that are pouring into our office; a copy is appended to this statement for the record.

But the health care access problems of uninsured Americans--or even of midlife women--are not solved by this new law. Many persons may not be able to afford the premiums to continue group coverage, or to convert to individual policies when temporary continuation ends. The law is not retroactive, and so does not help several million women who have already lost their coverage. It does not help high risk individuals who find they cannot purchase protection at any price. And it does not apply to employers with fewer than 20 employees.

Senator Kennedy's "Access to Health Care Act of 1986" (S. 2402) and companion bills (S. 2403 and H.R. 4742) address some of these problems. The bills require states to establish health insurance pools and funding mechanisms for uncompensated care, require employers to pay for continued coverage of laid-off workers for up to four months, and encourage more group coverage by small businesses and the self-employed.

OWL particularly endorses the establishment of state pools that market comprehensive health insurance to all residents regardless of health status (Section 2 of S. 2402). We believe it is absolutely essential that state pools keep the premiums affordable. S. 2402 recognizes the medically uninsurable--those who can't get any private health insurance--but there is less awareness of those who can't afford private health insurance. Without adequate premium control or premium subsidies, no Americans may be uninsurable, but millions may remain uninsured because they can't afford coverage. If they can't pay for individual private plans now, how can they afford premiums of 150% that amount?

- As written, the bill states that subsidy of an individual's premium or a premium based on income is not "prevented"; we urge the use of positive language encouraging states to build into their pools either sliding-scale premiums or some other form of assistance to individuals.

- Premiums will be less subject to large annual increases if pool funding is broadly shared by all; we believe that pool losses and subsidies should be shared by all insurers, including self-insured employers.

- Pools must not provide an incentive to employers either to drop their existing coverage or to refuse coverage to certain higher-risk workers, sending them to the pool for coverage instead; a special surcharge should be levied on all larger employers who don't provide a health plan for their employees, or who refuse to cover all employees in an existing plan.

As long as our private health insurance system is employment-based, employers must do their share to deal with those whon fall between the cracks. As another means of reducing the number of uninsured Americans, OWL supports the employer provisions of Section 4. Employers would be required to pay for continued coverage of laid-off workers for up to four months--many now extend such coverage--and to provide open enrollment for the working spouses of laid-off workers. Since such extension may come at a difficult time for employers, prefunding should be encouraged.

We also strongly support the provisions of Section 5 dealing with small businesses and self-employed individuals. As subcommittee members undoubtedly know, a high proportion of women work for self-employed persons or are employed in small businesses; particularly in the service sector, these jobs are not likely to include health insurance as an employee benefit. Providing these employers with tax incentives for establishing group plans and, through the Congressionally-mandated study, with ideas on keeping costs affordable will result in affordable group health insurance for workers and their families.

For persons with no private or public health coverage, access to health care is becoming increasingly problematic. Measures of uncompensated care don't begin to fully describe the dimensions of the problem, since they do not include those who simply don't seek needed care. All providers, insurers and consumers should equitably share in the cost of charity care. The mandates of Section 3 requiring states to set up plans for funding uncompensated care are welcomed.

The Older Women's League believes that access to affordable health care is a right, not a privilege. Our Board and members strongly supports the development of a comprehensive national health care program, with emphasis on health promotion and maintenance, available to all. To be without health care coverage in today's medical economy means either foregoing necessary treatment, using up life savings, or going disastrously into debt.

All Americans must have access to affordable health care, including long term care. As long as our health care system continues as a patchwork quilt of for-profit and nonprofit providers paid by public and private insurers (including employers, taxpayers and individuals), then we must find ways to cover those who are unprotected or inadequately protected.

We believe that this legislation represents exactly such solutions, piece-meal though they may seem to some. The Older Women's League stands ready to work with you on behalf of the "Access to Health Care Act of 1986" and we urge your colleagues to support its speedy passage.

NOTES

(1) "Women and Divorce: Health Insurance Coverage, Utilization, and Health Care Expenditures," Marc Berk, Natl. Center for Health Services Research, American Journal of Public Health 74 (Nov. 1984): 1276-1278.

(2) Detailed Diagnoses and Procedures for Patients Discharged from Short-Stay Hospitals, United States, 1984: Data from National Health Survey, Series 13, No. 86. National Center for Health Statistics, p. 4.

Hospitalizations	per 10,000 population, 1984
Under 15	620.1
15-44	1321.7
45-64	1832.8
65 and over	4003.6

Group Health Insurance Continuation

You are eligible to continue your current group health insurance coverage if you are: the widow/er or divorced spouse of a worker; the Medicare-ineligible spouse of a retiring worker; or if you or your spouse has been laid off, terminated (except for gross misconduct) or is working reduced hours. Dependent children are also covered.

The new law applies to private employers with 20 or more workers and to state and local government health plans.

You do not have to pass a physical examination, since you are already a member of the group plan. Your coverage simply continues, but you must pay the full monthly premiums—both the employer and employee portions, plus a 2% fee for administrative costs. Even so, most people will find that their current group health insurance plan is more affordable and provides better coverage than an individual policy.

The coverage ends if you fail to pay your premium, become eligible for other group coverage through employment, remarriage or Medicare, or if the employer ends group health insurance coverage for all workers.

The law is effective for health **plan years beginning after July 1, 1986.** The employer or health plan can tell you when your next plan year begins. If the plan year begins in August, the law takes effect for you in August 1986. If the plan year does not start until February, the law takes effect for you in February 1987. Some employers are voluntarily complying earlier than the law requires; check with your employer. For plans subject to collective bargaining, the law does not take effect until January 1987, or when the current bargaining agreements expire, whichever is later.

The Older Women's League is the first national membership organization to focus solely on the concerns of midlife and older women. OWL is a nonprofit organization with 15,000 members and more than 100 chapters throughout the United States.

OWL has advocated for group health insurance continuation since it was founded in 1980. OWL founder and former president Tish Sommers—who died in 1985—had been denied health insurance as a divorced woman in her early 60s because of her medical history. Six months before Sommers turned 65, the cancer that had made her ineligible for insurance recurred. Sommers was able to afford the necessary treatment, but she recognized that millions of divorced and widowed women are not so lucky.

OWL developed and actively sought passage of state legislation for group health insurance continuation for widows and divorced women. Seven states—Illinois, Kansas, Louisiana, Missouri, Oregon, Texas and Vermont—have passed legislation based on OWL's model state bill. This brochure is part of OWL's campaign to ensure that older women exercise their rights under this new federal law.

This brochure may be reproduced in whole or in part, with credit given to the Older Women's League. Single copies may be obtained by sending a stamped, self-addressed envelope to OWL. Contact OWL for information about the cost of bulk orders. Contributions and donations are welcome; membership information is available from: Insurance Continuation, OWL, 1325 G St., NW, Lower Level, Washington, D.C. 20005, (202)783-6686.

June 1986

Older Women's League

Group Health Insurance Continuation:

A New Law That May Help You Keep Your Health Insurance When Your Family or Work Status Changes

After July 1, 1986, many Americans who would otherwise lose their group health insurance coverage because of unemployment, divorce, or the death or retirement of a spouse will be able to keep their insurance—by paying their own premiums.

Older Women's League

An Introduction

Most Americans with private health insurance are covered through an employer. As a covered worker or family member, you have health coverage as long as you are employed or are related to an employed worker. But if your family or work status changes, you often lose your health insurance, too.

Women often lose health insurance coverage when they divorce, are widowed, or their husbands lose a job or retire. An estimated five million American women age 40 to 65 have no health insurance whatsoever.

Public Law 99-272, enacted in April 1986, will help many individuals retain their health insurance when work or family status changes.

This new federal law begins to take effect July 1, 1986. It may help you.

This brochure explains how to take advantage of your expanded right to continue group health insurance. It is not intended to provide legal advice. If you are divorcing, consult a lawyer before making decisions that may affect eligibility for health insurance continuation.

This new law will **NOT** help you if you have already lost your health insurance before it takes effect.

What Group Health Insurance Continuation Means For. . . .

Widows and Dependent Children

If you have health insurance through your spouse's employer, you and your children can continue that coverage for three years if your spouse dies after the group health insurance continuation law takes effect. The employer should notify the health plan when a worker dies; **check with the personnel office** to confirm this has been done. Within two weeks, the plan must notify you of your right to continue coverage. **You MUST respond** within 60 days if you wish to continue on the group health insurance plan.

Divorced or Separated Spouses and Dependent Children

If you have health insurance through your spouse's employer, you and your children can continue that coverage for three years if you divorce or are legally separated after the group health insurance continuation law takes effect. **Notify the health plan** of the change in marital status RIGHT AWAY. Within two weeks, the plan must notify you of your right to continue coverage. **You MUST respond** within 60 days if you wish to continue on the group health insurance plan.

One final note: Provision for health insurance may be included as part of a divorce decree; discuss this possibility with your lawyer. But remember that coverage ends if premiums are not paid, so **you should pay** the premium yourself and be reimbursed by your former spouse. Otherwise, late or missed payments could jeopardize your insurance.

Spouses and Dependent Children of Retiring Workers

If you have group health insurance through your spouse's employer and are not eligible for Medicare, you and your children can continue coverage for three years if your spouse retires after the group health insurance continuation law takes effect. **Check with the personnel office** to confirm that the employer has notified the health plan of the retirement. Within two weeks, the plan must notify you of your right to continue coverage. **You MUST respond** within 60 days if you wish to continue on the group health insurance plan.

Unemployed Workers and Dependents

If you have group health insurance through an employer, you and your dependents can continue that coverage for eighteen months if you become unemployed or your hours are cut after the group health insurance continuation law takes effect. This does not apply if you are terminated for "gross misconduct." The employer must notify the health plan of your termination. Within two weeks, the plan must notify you of your right to continue coverage. **You MUST respond** within 60 days if you wish to continue on the group health insurance plan.

Other Eligible Children

If you have group health insurance through your parent's employer, you can continue that coverage for up to three years if you become ineligible (for example, because of your age). Check with the plan to find out when you are no longer considered a "dependent child." **Alert the plan** as soon as you become too old to qualify. Within two weeks, the plan must notify you of your right to continue coverage. **You MUST respond** within 60 days if you wish to continue on the group health insurance plan.

SPBA SOCIETY OF PROFESSIONAL BENEFIT ADMINISTRATORS
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Testimony of
The Society of Professional Benefit Administrators (SPBA)

U.S. Senate Labor and Human Resources Committee
Barriers to Health Care Hearing
July 16, 1986

by: Frederick D. Hunt, Jr., SPBA President

The Society of Professional Benefit Administrators (SPBA), founded in 1975, is the national association of independent third party contract benefit administration firms. It is estimated that one third (1/3) of all U.S. workers are covered by employee benefit plans administered by such firms.

SPBA members operate much like independent CPA or law firms... providing continuing professional out-of-house claims and benefit plan administration for client employers and benefit plans. Most of the plans employ at least some degree of self-funding. Client plans include those sponsored by corporations of all sizes, associations, and union/management jointly-administered Taft Hartley multi-employer plans.

SPBA membership has grown almost 700% in the past 6 years... with a current roster of almost 400 member firms. Similarly, SPBA members have seen the market for their services also expand rapidly...in large part because of the leading role of SPBA members have played in successful health cost containment efforts and cost-efficient administration techniques for pension and health benefit plans.

Mr. Chairman and members, thank you for allowing SPBA the opportunity to submit written testimony for this hearing. Our comments concern Senate bills S 2402 and S 2403, Access to Health Care Acts of 1986,which were introduced by Senators Kennedy and Durenberger,respectively.

SPBA brings one of the most comprehensive perspectives of employee benefit issues. It is estimated that one-third (1/3) of all U.S. workers are covered by plans administered by SPBA member Third Party Administration (TPA) firms. These plans cover every size and format of employment. Thus, our comments are not geared to one size or type of industry, and include both unionized and non-union employees.

We submit as our testimony the following points. I understand that these forecasts and comments are consistent with the feedback your staff have been receiving from plan sponsors and employers around the country.

John Timmer, Chairman of the Board Employee Services, Inc., Sioux Falls, SD
W. Ashley Harden, Vice Chairman Harden & Company, Concord, CA
William C. Earhart, Bd. Secretary/Treasurer William C. Earhart Co., Portland, OR
Robert B. Swanke, Immed. Past Chairman Swanke, Inc., Minneapolis, MN
T. J. Chapman Boon-Chapman, Ltd., Austin, TX
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Frederick D. Hunt, Jr. President

Past Chairmen's Council Robert E. Kelly • Steven L. Sherman • Glen K. Slaughter • W. Richard Perkins • James M. Dawson

1. "BIG BROTHER"...in its most unkind connotation....is the perception given when Congress decided to supercede the intelligence and rights of workers and employers to determine the most appropriate benefit package in each employment circumstance. This philosophical objection to this intrusion has raised deep resentment across the country.

2. LOSS OF BENEFITS will occur in order to pay for this and other new Federally-mandated benefits. Money contributed for employee benefits does not come from a bottomless pit. Only a set amount will be dedicated for that purpose. Therefore, if the requirements of this kind of legislation are mandated...then something else desired by the workers will be killed or drastically cut back to make up for the cost of the new mandated benefit. Pensions, vision, dental, or disability coverage are likely first victims.

3. TERMINATION OF WHOLE BENEFIT PLANS is quite likely and logical. This legislation is not operating in a vacuum. There are half-a-dozen major expensive Federally-mandated benefits or cost-shifting from government programs to private employee benefits this year. Not only does this mean billions of dollars of extra cost for employers (or off-set lowered/terminated benefits)... but every year major new expensive administrative hassles are added for plans and sponsors. For these reasons...and because government policy chooses to punish only employers who are already voluntarily seeking to aid their employees and families...Uncle Sam is actually strongly encouraging the termination of all employee benefits, since that is the only way to escape the laws and expense.

4. PAYING FOR UNRELATED PERSONS is directly contrary to longstanding Federal employee benefits policy. Both ERISA and the tax code have stringently limited coverage to those who have a "direct employer-related bond". If coverage for unrelated people is a desired public goal...then it should be spread over all of society via a public tax.

5. FORCING STATES to operate in a certain way (pools & charity reimbursement) within an area which is specifically delegated to the states under the Federal McCarran-Ferguson Act provides an interesting question of constitutional law and strongarm tactics. Punishing employers if (beyond the employer's control), the state does not go along with this tactic is an even more aggravating frustration.

6. POOL BANKRUPTCY is almost assured to be a routine occurrence, since the funding conditions are being set politically in Washington D.C. rather than actuarially in the states where the local conditions are known. In the case of such bankruptcies, employee benefit plans will be hit with extra assessments for which they had no way (or authority under the tax code) to prepare. For the 40+% of Americans covered by self-funded plans, the Tax Reform Act of '84 (DEFRA) sections relating to VEBA reserves must be drastically changed... or else prepare for the plans to bankrupt due to Federal mis-planning.

7. MORE MONEY THAN UNCLE SAM ENVISIONS is at stake for employee benefit plan sponsors. Not only is there the initial extra money for state pools, and then an extra assessment when those pools routinely go broke...but there is also the vague description of reimbursement for what is now charity care. Even the proponents of this legislation claim that that is a huge potential sum of money. Presumably, this money will also come from employee benefit plans (thus causing still more cut-backs and terminations of desired coverage)...or from state budgets. It should be noted that Uncle Sam's generosity...which will probably end up costing states directly and indirectly...comes at a time when the Congress is also considering cutting the state-tax deduction on Federal income tax forms. Thus, state taxes will have to rise by Federal fiat... and then might not be deductible.

8. HMOs, BLUE CROSS, SELF-FUNDED, & GOVERNMENTAL PLANS WILL BE CHEATED. While insurance companies have been participating in state pools in less than 20% of the states, as part of their desired regulation by state governments... it must be remembered that such contributions to state pools are fully deductible and often off-sets of premium taxes in those states. However, HMOS, Blue Cross, self-funded, church, and city/state governmental plans are non-profit and thus neither have the tax deduction nor the premium tax off-sets. Thus, this provides a distinct price disadvantage to the non-profit groups.

9. HYPOCRITICAL seems the best description of the proposed HHS commission to encourage small businesses to lower health coverage costs and provide benefits. As noted, this legislation and the many other unrelated well-intentioned-but-counter-productive mandates and cost-shiftings are simply nails in the coffin of employer willingness (especially smaller cash-flow-sensitive ones) to help provide for their employees. There is also skepticism that any such Commission action would either be prejudiced from the start...or too late in coming to reverse the legislation.

Again, we appreciate the opportunity to have some input into this legislation. We urge you to look beyond the mirage of instant benefit...to the real effects for the intended beneficiaries and for society as a whole. If we can be of assistance, please do not hesitate to call upon us.

Society of Professional Benefit Administrators

SPBA

* MEMBER *

July 16, 1986

Statement of

Patrick F. Killeen
Assistant Director, Social Security Department
International Union, UAW

on the subject of the

ACCESS TO HEALTH CARE ACT OF 1986
(S. 2402)

before the

Committee on Labor and Human Resources
United States Senate

In behalf of:

International Union, United Automobile,
Aerospace and Agricultural Implement
Workers of America (UAW)

Mr. Chairman, I am Patrick F. Killeen, Assistant Director and Senior Health Care Consultant for the Social Security Department of the International Union, United Automobile, Aerospace & Agricultural Implement Workers of America (UAW). The UAW appreciates the opportunity to testify before this Subcommittee concerning the proposed "Access to Health Care Act of 1986" (S. 2402). I appear on behalf of 1.5 million active and retired UAW members, including many thousands of UAW members who have lost their health insurance coverage due to unemployment. We commend this Committee for addressing the unmet health care needs of uninsured individuals, one of the most serious problems we face as a nation.

The UAW is firmly committed to the principle that all individuals should have access to adequate health care as a basic human right. Unfortunately, this right is not a reality for many Americans.

The extent and seriousness of the lack of health insurance is well known. The Bureau of Labor Statistics estimates that one-third of laid off workers have no health insurance coverage of any kind. This translates into millions of people, including more than 200,000 displaced members of our Union, who have lost essential family health protection as a result of layoffs.[1] The impact of job loss on health insurance coverage is usually immediate. According to a Department of Labor study, close to 60 percent of workers lose their health protection immediately or within a month of layoff, and only 20 percent have protection beyond three months.[2] A recent University of Michigan study shows that in the Detroit area 51 percent of unemployed individuals were without health insurance. Of this group, 78 percent lost insurance as a direct result of having lost their jobs.[3] Those workers who are lucky enough to get new jobs often have to wait months for coverage that is substantially poorer in benefits than their previous coverage. The dimensions of this problem become enormous when one considers that approximately 21.5 million people, nearly 17 percent of the population, will be without work for all or part of the year.[4]

Of all the industrialized nations, only in South Africa and the United States, which have no national health plans, is the tragedy of unemployment compounded by the fear and insecurity caused by loss of family health care protection. The limited budget of the unemployed is seriously strained by competing essential priorities. Mortgage or rent payments, threatened utility cut-offs, merely putting food on the table, are the harsh everyday realities. There is no money for health insurance. As a result, receipt of necessary medical treatment is often ignored or delayed with sometimes serious consequences. A study of laid off auto workers in Michigan by the Social Welfare Research Institute indicates that 17 percent of laid off workers do not even try to seek needed care.[5] This is a shocking situation.

Looking beyond the difficulties of those laid off, we find a problem even more staggering. The number of Americans without any public or private health insurance is now 35 million people.[6] When those who lose insurance protection for short periods of time are included, the total is well over 50 million people.[7] A recent study by the Robert Wood Johnson Foundation found that one million Americans are refused medical care annually because they cannot pay for it; another five million do not even seek care they feel they need because they know they cannot afford it.[8]

Many of the problems we currently face in providing health care for the uninsured have been aggravated by the increasing corporatization of medicine and the Reagan Administration's approach of promoting growth of the for-profit sector in health care. Previously, public hospitals and not-for-profit community hospitals provided care for the uninsured by subsidizing that care through charges made to insured third-party payers. However, the growth of for-profit hospital chains has severely reduced these types of social subsidies for the poor and uninsured. Because of heightened competition in the health care industry, the not-for-profit community hospitals have increasingly been financially unable to continue to provide care for those without adequate health insurance.

Future forcasts call for more of the same. According to Dr. Arnold Relman, Editor of the New England Journal of Medicine, and a leading critic of for-profit health care entrepreneurs, as many as 180 public hospitals were purchased or came under the management of for-profit hospital chains between 1970 and 1980. He also warns that 30 percent of all hospitals will be chain-owned by 1990 if the current rate of expansion continues.[9] The American College of Hospital Administration makes an even more alarming prediction, estimating that by 1990, chains will own 60 percent of U. S. hospitals.[10] This will result in less and less health care being made available to the poor and uninsured, thereby increasing the financial burden on already desperately strapped individuals and nonprofit and public hospitals.

Recognition of the serious plight of the uninsured has spawned a number of voluntary efforts on the part of community leaders, labor unions, hospitals and physician groups around the country to provide some health care services for the uninsured. Several states have also established subsidized insurance pools for those without access to employment based health insurance. Others have established systems to fund hospital care for the uninsured. Although such efforts are commendable, they fall far short of what is needed and many problems remain. These efforts are geographically scattered and uncoordinated; they do not address much of the known need; and they often fail to provide adequate financial support to pay for health care services for those least able to afford it — the poor and the unemployed — leaving this financial burden on the already severely burdened public and nonprofit community hospitals.

The Medicaid program also fails to provide adequate access to health care for the unemployed and uninsured. Although Medicaid provides health care coverage to the poor, because of stringent eligibility criteria it does not cover many unemployed and uninsured persons. According to the University of Michigan study, only 25 percent of the unemployed had Medicaid coverage for either themselves or for their children.[3] This problem has been exacerbated by cut-backs in Medicaid promoted by the Reagan Administration. Many unemployed persons are also ineligible for Medicaid because they are first required to deplete assets acquired while they were employed. The UAW submits that no one should be required to become impoverished in order to be able to get access to adequate health care services.

The UAW believes that only the ultimate passage of a comprehensive national health security program will adequately remove the barriers to access to health care for the millions of unemployed and uninsured individuals in this country. We continue to find widespread support for a national health program around the country.

In the short term, there is an urgent need for federal legislation to improve access to health care for the unemployed and the uninsured. The UAW commends the Ranking Member of this Committee, Senator Kennedy, for introducing the the proposed "Access to Health Care Act of 1986" (S. 2402). We believe that this legislation would represent an important first step in meeting the unmet health care needs of millions of persons in this country. We urge the Committee to give this legislation prompt, favorable consideration.

The UAW is particularly pleased that Access to Health Care initiative would begin to help alleviate some of the problems faced by laid off workers and their families in obtaining access to health care. Most importantly, S. 2402 would require employers to continue health care coverage for at least four months after workers are laid off. Employers would be required to continue whatever level of coverage and employer contributions were previously offered to active workers. This would help to bridge the gap in health care coverage for a large segment of the unemployed.

Some large corporations already continue health insurance coverage for laid off workers. For example, under major UAW contracts, health insurance coverage for laid off workers may continue for up to two years, depending on length of seniority. But these contractual benefits are not typical for most workers, nor for many members of our Union in independent parts and supplier plants, who often lose health insurance coverage at the point of layoff.

This provision in S. 2402 builds upon the health care continuation provisions contained in the Consolidated Omnibus Budget Reconciliation Act, which requires employers to allow laid off workers to continue, at their own expense, coverage under their employer's group health plan for up to 18 months. In addition, widows and widowers, divorced spouses, spouses not yet eligible for Medicare and dependent children have the right to continue coverage under the employer's group health care plan for up to 36 months, again at their own expense. While these provisions are helpful and a step in the right direction, they do not solve the problem faced by the unemployed in obtaining access to health insurance coverage. This cost is simply prohibitive for most unemployed persons, given their already strained family budgets. Indeed, prior to the passage of the group health care continuation provisions in the budget reconciliation measure, only about one percent of the persons in Michigan who lost coverage under their employer's group health care plan elected to convert to individual policies, which typically cost less than group policies because they offer substantially fewer benefits.[11] Accordingly, it is apparent that very few laid off workers will actually be able to afford to exercise their option to continue coverage under the employer's group health care plan, which usually is even more expensive. To make health care coverage affordable for laid-off workers, government or employer contributions are critical.

In 1983, the House passed legislation to provide health care for the unemployed (H.R. 3521). This bill, which was supported by the UAW, would have required employers to continue health care coverage for laid-off workers and also would have authorized funds for a federal program to provide health care for the long-term unemployed. Unfortunately the Senate rejected efforts to provide federal funds for this purpose; however, it never took up the issue of requiring employers to continue insurance coverage.

The health care initiative introduced by Senator Kennedy would not create a new federal program. Instead, it simply embraces the concept that employers should be required to continue health care coverage for laid off workers for a period of time. Although the UAW believes that any solution to the problem of health care for the unemployed necessitates some federal program, the private sector initiative contained in the Kennedy bill would still make an important contribution towards providing improved access to health care for the unemployed.

The health care continuation provisions in S. 2402 will actually help to reduce federal and state expenditures. When employers fail to continue health care coverage for laid off workers, the costs of providing coverage do not disappear. To the extent that care is provided, much of these costs are simply shifted onto other payors -- either the federal and state governments under Medicaid, or onto the public and non-profit community hospitals who handle most charity care. Requiring employers to continue health care coverage for laid off workers will reduce this cost shifting, and thus will actually reduce Medicaid expenditures by the federal and state governments (as well as relieving the burden on public and non-profit community hospitals).

Requiring employers to continue health care coverage for laid off workers will not impose an undue burden on businesses. In most cases, these additional costs will represent only a small fraction of the overall health care expenditures by the employer. And employers always will have the option of pre-funding these liabilities, so that they are prepared for economic downturns.

The UAW would also like to comment briefly on the other sections of the Access to Health Care initiative. S. 2402 also would give the spouses of workers who lose their jobs the right to enroll in the health care plan offered by the spouse's employer. All too often, whole families lose essential health protection because the spouse with family health care benefits loses his/her job, and the other spouse is precluded from enrolling in his/her employer's health care plan. S. 2402 would effectively solve this problem by creating an automatic enrollment window period for the still employed spouse.

The UAW also believes that the provisions requiring the states to establish a system to fund hospital care for the uninsured and the poor are commendable. The need for such state systems has been made even more intense by the increased competition between health care providers, who are compelled to offer less and less care to the poor and the uninsured because of reduced subsidies for such care from Medicare and other third-party payers. Moreover, the establishment of state systems to fund hospital care for the uninsured and the poor would help to alleviate the strain that uncompensated care currently places on public and non-profit community hospitals, whose survival is becoming increasingly threatened. Many of these hospitals are in areas of high unemployment or in rural areas, where they are the providers of last resort for a growing number of individuals.

The UAW urges the Committee to give careful consideration to certain details of this proposal. For example, federal standards need to be included to insure that such systems do not exclude significant numbers of the needy through too stringent eligibility standards or through the use of copayments. Similarly, the level of benefits available under such systems needs to be spelled out in more detail, as well as the provisions dealing with patient ability to pay. The legislation also leaves the states considerable discretion as to the type of funding mechanism which can be utilized. The UAW believes that health care providers, health insurers, and the federal and state governments all should participate in any financing mechanism, in order to assure a complete and successful response to the problem of uncompensated care. We are also concerned that the penalty which would be imposed on states that fail to establish an appropriate system — eliminating federal funds for the state's Public Health Service Act programs -- could have an adverse impact on health care for the poor. We urge the Committee to explore other possible penalties, such as denying tax-exempt bonds for hospital construction and equipment acquisition unless there is an appropriate state system to handle uncompensated care.

The UAW also supports the provisions dealing with the creation of subsidized state insurance pools for the "uninsurable". Through such mechanisms, the states can guarantee the availability of health insurance to individuals, regardless of their health status. Currently, there are many individuals who do not have access to employment-based health insurance who cannot obtain private insurance on their own because of pre-existing medical conditions. This proposal would assure that these individuals have access to health insurance at affordable rates. However, we believe that some of the details of this proposal require additional consideration. In particular, we believe that all employers ought to be required to participate in and help share the costs of these state pools, not simply employers that currently offer insured or self-insured health care plans. Otherwise, the states will be in the position of rewarding those employers who choose not to offer any health care coverage to their employees.

In conclusion, the UAW would again like to commend Senator Kennedy for introducing the Access to Health Care Initiative. We believe that this package of proposals represents an important first step towards meeting the urgent problem of providing adequate access to health care for millions of uninsured persons in this country. The UAW looks forward to working with the Members of the Committee as it considers this important legislation. Thank you.

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TESTIMONY OF BERT SEIDMAN, DIRECTOR
DEPARTMENT OF OCCUPATIONAL SAFETY, HEALTH AND SOCIAL SECURITY
AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS
BEFORE THE SENATE LABOR AND HUMAN RESOURCES COMMITTEE
ON ACCESS TO HEALTH CARE SERVICES

JULY 16, 1986

The AFL-CIO is pleased to present testimony today in support of S. 2402, the Improved Access to Health Care Initiative. We in organized labor share the committee's concern about the dramatic growth over the past five years in the number of citizens without health insurance protection and, thus, without regular access to the health care delivery system. A less obvious problem, but with equally serious ramifications for policy makers, is the shocking jump in the number of individuals who are judged to have inadequate health insurance coverage. A recent study by the Washington, D.C. Government Research Corporation estimated this population to be as large as 50 million. Adding this to the 35 million known to be without any health care protection, two-thirds of whom are in the workforce or their dependents, there is a total universe of 85 million people who do not have adequate access to health care services.

The AFL-CIO strongly believes that the best medicine for this problem would be the enactment of a national health care system, which makes access to basic health care services a right for all Americans. Of all the industrialized countries except South Africa, only in the United States is health care coverage tied to one's job or other source of income and the decision whether to provide coverage left to an individual's employer. Only in the United States are individuals with chronic health care problems locked out of the system because they cannot obtain insurance protection. And only in the United States are children of the working poor and retirees who are not yet eligible for Medicare denied early treatment for potentially serious medical conditions because of a lack of protection and an inability to pay for health care services.

The problem of the uninsured and underinsured has escallated as a result of a confluence of public and private sector events. There have been cutbacks in public programs to the point where Medicaid now covers less than 50 percent of those living under the poverty line. Because of excessive increases in the cost of insurance, purchasers in the private sector have become more "price sensitive" and increasingly unwilling to subsidize the cost of care to the uninsured, which now amounts to approximately $6 billion nationally and threatens the very existence of public hospitals and "providers of last resort" for those without coverage or with inadequate protection.

We commend you, Mr. Chairman, and the other sponsors of S. 2402 for introducing legislation which could help to provide much needed health care protection for those who are currently uncovered. However, we do have a number of concerns about the bill.

First S. 2402 will address the short-term health care needs of the unemployed who, when laid off, not only experience the trauma of joblessness but also lose their link to the health care system. Although we view the requirement that employers continue coverage for four months after layoff as a positive step, it will not address the needs of the 25 percent of the unemployed who have been jobless for more than 4 months. Conceivably these individuals might have a higher probability of obtaining treatment with the enactment of the bill's requirement that states establish a mechanism to provide funding to hospitals to offset bad debt and charity care. However, a study published in the May 1, 1986 edition of the New England Journal of Medicine demonstrates what many health policy analysts have known for some time: that health care indirectly funded in this manner is far less adequate than services provided under public programs, such as Medicaid.

Second, we are concerned that, absent any targeting requirements in the bill for state insurance pools, public hospitals and other facilities serving a disproportionate share of patients without insurance protection may not receive their "fair share" of funds. We believe that the federal legislation should require states to give priority to these institutions and encourage hospitals to provide outpatient care when appropriate.

Third, although the bill attempts to limit what constitutes bad debt and charity care by specifying what would not be reimbursable under this section, it neglects to mention shortfalls as a result of hospital discounts given to large non-governmental payors. We believe that such a provision should be added to bar facilities from shifting the costs of such discounts on to state uncompensated care pools.

Fourth, we believe that somewhere in the bill a definition of "bad debt and charity care" and "underinsured" ought to be spelled out.

Fifth, if Congress intends to allow states to deal with the uninsured and underinsured problem by allowing them to set up a managed system of care, then it should specify what it means by managed care, in addition to requiring some basic quality controls to protect the health of potential participants.

With respect to the issue of requiring employers to contribute to a state pool for individuals who cannot obtain insurance protection because they are chronically ill or at high risk of becoming ill, the AFL-CIO supports the principle underlying this provision that there should be an equitable risk-sharing arrangement to distribute the cost of care for victims of chronic diseases. We have long held that individuals and their employers should not be unfairly penalized for poor health status and would view the enactment of this provision as a positive step forward. Although some states are now considering establishing such a pool, only nine have actually done so.

On the other hand, although the bill sets a maximum on premiums that can be charged to individuals participating in state risk pools, this cap will no doubt become the only rate, leaving us with serious concerns about the potential pool of eligibles who will not be able to afford such coverage. Both the premium and out-of-pocket maximums, which also are certain to become the exclusive amounts may be affordable only to families with relatively high incomes. In the interest of equity, we believe that the committee should consider instructing states to establish a sliding scale based on income for premium requirements, as well as out-of-pocket payments. Currently, the bill would merely not prohibit a state from doing so. In addition, it should be clearly spelled out in the bill that a state may not charge higher rates to those individuals with relatively poor medical histories.

Before concluding our statement, Mr. Chairman, the AFL-CIO would like to inform the Committee that it has been working with a group of its affiliated unions and consumer organizations to develop a model initiative of our own to address the needs of the uninsured and underinsured. Our model, which will be available shortly, has a federal and state component. Like S. 2402, it would offer states various options for improving access to care. However, we recommend requiring states to establish a public commission, with a majority of its members, health care consumers, to implement such a plan. It would also require that hospitals with the greatest need be targeted for relief from expenditures for bad debt and charity care, and it would set out general guidelines for case management systems and it would require hospitals that receive funds to establish systems by which outpatient care can be provided to patients in situations where inpatient care is not warranted. In addition, to the federal component, we are preparing a model state bill that would take the next step and implement the federal guidelines. At the appropriate time we would be pleased to share this model with the Subcommittee and staff.

Again, we would like to commend the Subcommittee for taking the initiative in attempting to improve access to health care services for the uninsured and the underinsured and are prepared to work closely with you to pass this important initiative.

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TESTIMONY OF

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VICE-PRESIDENT
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SCHOOLS

ON BEHALF OF THE

NATIONAL HEALTH COALITION FOR MINORITIES
AND THE POOR

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

CONCERNING

BARRIERS TO HEALTH

JULY 16, 1986

Mr. Chairman and Members of the Committee, thank you for the opportunity to offer our comments on Barriers to Health Care and Proper Access. We commend you and Senator Kennedy for your keen interest in this issue.

I am Dr. Louis W. Sullivan, President and Dean of the Morehouse School of Medicine in Atlanta, Georgia; Vice President of the Association of Minority Health Professions Schools; and Coordinator of the National Health Coalition for Minorities and the Poor. This national health coalition was formed by the Association of Minority Health Professions Schools and a number of other organizations concerned with devastating problems of our nation's poor and minority citizens. We believe that many Americans are unaware of the vast dimensions of this problem. To us, there seems to be no other explanation for why so many citizens who have so much to contribute to our society, should be living their lives without adequate medical care.

Amongst us, each organization has first-hand knowledge of the desperate national situation that exists in this country's ability, and its willingness to provide access to basic health services for the nation's many, many poor and minority citizens and families who reside in medically under-served inner-city and rural areas. We speak for those who do not have the financial means to seek the right of the good health and longevity. Those of whom we speak of are not just the indigent and homeless who roam our city streets. We speak also of the over 35 million in our country who are unemployed or temporarily unemployed, those without medical insurance, those who are discriminated against, those who have little or no money, and those who live in areas where there are inadequate medical services and/or too few providers located nearby.

At a recent national conference on Health Care for the Poor held in Nashville, Tennessee at the Meharry Medical College, it was noted that there is a widening gap in health status among the nation's poor and minorities and the nation's majority population. Further, in August, 1985 a Task Force appointed by the Secretary of the Department of Health and Human Services reported a significant gap in health status among the nation's blacks and other minorities when compared to the nation's white population. Black infants are twice as likely to die in their first year of life as are white infants. The life expectancy of blacks is five years less than that of whites. The Secretary's task force reported that annually in the black community almost 60,000 excess deaths occur because of the disparity in the health status. Evidence presented by both of these efforts also indicates that the problem is growing, not getting better. Unfortunately, in the face of this widening disparity, the Reagan Administration has consistently proposed to eliminate or severely cut a broad range of the federal programs that provide assistance to the poor and minority populations of the country.

Mr. Chairman, our Association has appeared before your panel in previous years to discuss the importance of health professions and biomedical research programs authorized by your Committee. It is documented that black health professions are more likely to locate their practices in under-served minority areas. This alone makes the case for continued emphasis on federal health professions training support for minority institutions and the students who attend these institutions. Further, there should be an establishment of centers of Research and Training Excellence at minority institutions for the purpose of researching those diseases and illnesses that are more common to Blacks, and for training of young clinicians, investigators, and scholars. These two small initiatives, we believe, will have a significant positive impact upon the continued problem of poor access to health care for minority and poor persons who live in under-served areas.

Please allow me to thank you for asking us to provide a statement for this hearing. Also, I wish to thank you and Senator Kennedy for the supportive statement you each made recently in support of our Association's efforts to close the health status gap.

Thank you for the opportunity to present our views.

PUBLIC HEALTH FACTS ABOUT MINORITIES AND THE POOR

In terms of life expectancy at birth, white females can expect to live about five years longer than black females and white males can expect to live 6.3 years longer than black males.

The black infant mortality rate is almost twice as high as the white infant mortality rate (19.2 versus 9.7 deaths per 1,000 live births).

The neonatal (first month of life) mortality rate for black infants is 94 percent higher than for white infants (12.4 percent versus 6.4 deaths per 1,000 live births).

In deaths caused by stroke, the death rate is twice as high for blacks.

The death rate from heart disease for black females is twice that for white females.

Twice as many black infants suffer from low birth weight than do white infants.

Black people and Puerto Rican and Cuban Americans lack health insurance at twice the rate of white people.

Public general hospitals have about twice the proportion of minority patients than do voluntary hospitals.

Mexican and Cuban Americans have the highest rate of no physician visit during the past year.

In 1981 about 40 million people were living in places defined by the federal government as primary medical care shortage areas.

Black physicians and pharmacists comprise only two to three percent of the total supply of these practitioners, while blacks comprise 12 percent of the population.

The number of minority health school entrants will have to double to meet the medical needs of minorities, according to a report by D.H.H.S.

Sources: "Health United States," D.H.H.S., Public Health Service, 1983, 1984, 1985.

STATEMENT ON S. 2402
(and its companion S. 2403)

by

Charles W. Rogers

on behalf of

EMPLOYERS COUNCIL ON FLEXIBLE COMPENSATION

July 18, 1986

My name is Charles W. Rogers. I am Vice President of Compensation and Benefits at PepsiCo, Inc., and Chairman of the Employers Council on Flexible Compensation. I appreciate this opportunity to provide the Committee with comments on S. 2402 on behalf of both organizations.

PepsiCo, Inc. is a company with approximately 120,000 employees nationwide. The Employers Council on Flexible Compensation (ECFC) is a membership association of more than 100 corporate sponsors of elective plans for health and other benefits. Collectively, these corporations have more than a million employees.

* * *

S. 2402 and its Senate companion, S. 2403, are intended to expand access to health care insurance. The bills mandate employers to finance up to 4 months of continued health care for terminating employees and their dependents. In our opinion, this approach will not improve health coverage, but it runs the risk of dissuading employers from providing benefits to workers who can least afford to protect themselves. These proposals come just months after the enactment of legislation mandating the continuation of coverage at employer-subsidized rates. In addition, the bills run counter to the intent of the congressional budget process by effectively creating an off-budget program of taxation and spending.

Over-regulation and mandated benefits will kill private initiative for employee health care insurance. Currently, private employer plans are the backbone of the health insurance system. But employer plans may be cut back or eliminated. We have seen it in the pension area, where government regulation (all well intended) has led to the termination of thousands of plans. Employers, particularly small and medium-sized companies, will not accept the excessive burdens imposed by this legislation. The bills signal a pattern of continuing regulation -- and constant change -- that will drive thousands of employers out of health care plans.

We feel it is unreasonable to mandate an employer to provide up to four months of employer-paid coverage. Many small and medium-sized employers (like PepsiCo's Pizza Hut and Taco Bell franchises and our independent Pepsi-Cola bottlers) may be forced to drop their health plans. Large employers may be forced to cut their plans back -- eliminating coverage for new hires and for higher-turnover positions.

The proposed legislation will be prohibitively expensive. PepsiCo's cost for 4 months of coverage averages $800 per covered employee. The total annual cost figure for PepsiCo's directly-owned businesses could run as high as $9 million. If we count our franchised restaurants and bottlers, this figure could easily double. CBO estimates that the annual cost for all employers could be as high as $2.4 billion.

It troubles us that Congress is considering such a radical approach just months after enacting a sweeping requirement extending health care coverage. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) already requires employers to offer coverage to terminating employees and their beneficiaries (and certain others) at employer-subsidized rates. COBRA's cap on the amount employers may charge for extended coverage bars employers from passing along the full actual cost of the coverage. We believe the COBRA provisions represent an unnecessary extension of existing health benefit plans. Under the circumstances, we believe any new requirements on employers should not be considered until the full impact and cost of COBRA is known.

In addition to mandating 4 months of employer-paid coverage, the pending bills seek to establish state pools for health care insurance. As drafted, these provisions provide no assurance that the pools will be operated in a sound self-sustaining manner. Even in well-operated existing pools, coverage at the contemplated premium levels requires significant and ongoing subsidy. Since employers would make up any deficits, this represents another case of off-budget taxation and spending. Moreover, the pool would make employers reponsible for the health insurance needs of individiuals with whom they have never had an employment relationship -- indirectly creating an employer-subsidized national health insurance program. We believe the pool potentially represents an even more damaging precedent than the four-month extension provision.

S. 2402 and S. 2403 would derail successful programs of privately funded employee health care insurance. We feel very strongly that this legislation must not be enacted.

SUMMARY STATEMENT OF

MICHAEL O. ROUSH
CHIEF SENATE LEGISLATIVE REPRESENTATIVE

NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Before: SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
Subject: Barriers to Health Care
Date: July 16, 1986

Mr. Chairman my name is Michael Roush. I am the Chief Senate Legislative Representative for the National Federation of Independent Business. NFIB is a voluntary membership organization with over 500,000 small business owner members. Our membership comes from all of the industrial and commercial categories and reflects the national small business community in its distribution among industries. That is, we have about the same percentage of members in the construction industry, the manufacturing industry, wholesale, retail, etc., as exists in the national business profile. I appreciate this opportunity to participate in your committees investigation into the barriers to health care.

I am not an expert in the health care industry or in the insurance industry, therefore my remarks are primarily directed to a description of the attitudes and operational characteristics of the small business community that are relevant here. The primary basis for my remarks come from two national surveys we have conducted in this general area. The first was done in 1978 and is entitled National Health Insurance Report on Small Business. The second, conducted in late 1985, is entitled Small Business Employee Benefits. In addition to these survey results we also periodically poll our entire membership on their attitudes toward public policy issues. First, I will summarize some of the results of our survey material, then I will briefly discuss their policy implications from small business' point of view.

The number of small business owners providing employee health insurance has been rising. Sixty five percent of firms offer health insurance for at least some full time employees, an increase of eight percentage points from a similar finding in 1978. Forty two percent of small firms provided health insurance to all full-time employees.

The vast majority of firms in all size categories offer plans that include hospitalization/surgical and major medical. In the aggregate, nearly two-thirds of these employers pay the entire premium cost, with smaller firms more likely to pay 100% of the premium than larger firms. Most responsible for the increased coverage are firms in financial service, professional service, retail, and smaller firms in general.

Well over 80% of health insurance plans offered in small firms carried an option for dependent coverage. However, few part time employees were provided any health benefits.

The mean health insurance premium paid by small employers was over $1,766.00, more than double the monthly premiums paid in 1978.

Small business owners purchased private health insurance from a great variety of carriers. Self insurance (4%) and HMO (3%) remained an oddity among small firms.

While the firm was the group sponsor more often than not, trade/business associations have been increasingly taking that role. We believe, the trend to greater association sponsorship is tied directly to increasing employee health coverage in small firms.

Small business owners and/or a designated employee spent comparatively little time searching for health insurance alternatives, health care cost control options, etc. Outside advisors, particularly insurance agents, often substituted for owner/employee search.

Employee health insurance was not provided by about 1/3 of small employers. No single reason dominated their decisions. The most frequently cited reasons were: employees covered under a spouse or parent policy (secondary wage earners), premiums were too high, employee turnover was too great, the firms profitability was insufficient, or the firm couldn't qualify for a group policy.

While small employers will increasingly provide health insurance for their employees, it is unclear just how dramatic this increase will be. The composition of the labor force and differences in small business profitability will limit growth in the proportion of small business owners instituting employee health insurance plans. Coverage will continue to increase as health care cost decline, labor markets accept it as a condition of employment, and as associations make group plans increasingly accessible to the smallest firms.

Blending our survey results with our policy polls, small business overwhelmingly opposes any government-mandated health insurance program, or, indeed, any government mandated minimal insurance coverage. The 1/3 of small firms which are not now offering any health insurance to their employees are not doing so primarily because of labor market composition problems or profitability problems--neither the small business nor the government can change these realities. If, however, policy makers decide to mandate certain requirements in this area, in order to try to get coverage for certain target groups they must be careful not to create new gaps or new barriers by discouraging voluntary employer sponsorship of health insurance plans! Policy could minimize this potential:

o by not requiring a period of employer paid insurance benefits beyond job termination;

o by exempting seasonal and short-term employees from coverage;

o by recognizing the large proportion of secondary wage earners in small businesses and eliminating the potential for their double coverage;

o by provisions to allow for sharing the cost between employers and employees, unless otherwise privately agreed upon;

o by keeping any such program simple and in the private sector to the greatest extent possible and by keeping paperwork and recordkeeping to an absolute minimum;

o and by not even considering increasing payroll taxes to pay for any such programs, premium payments would be most appropriate.

The other major reasons for small business non-coverage of employees are that premiums are too high and that their firms do not qualify for group policies. These aspects of the problem may be more amenable to public policy correction, but I will leave that judgment to others for the moment. The market does seem to be moving to correct even these barriers to coverage.

What all this means for NFIB's position on S. 2403, The Access to Health Care Act of 1986, is as follows:

- we oppose employer paid health insurance beyond job termination as too expensive and an administration nightmare (section 4);
- we support the health insurance deduction for self employed individuals (section 5);
- we support the call for studies and demonstration grants on ways to reduce the costs of health insurance for small businesses (section 6);

- we have reservations about the statewide pools and the open enrollment period for spouses of unemployed workers (sections 2 and 4);
- and we are neutral on requiring state programs for the uninsured and underinsured (section 3).

STATEMENT OF

MICHAEL O. ROUSH
CHIEF SENATE LEGISLATIVE REPRESENTATIVE

NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Before The

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

July 16, 1986

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INTRODUCTION

Mr. Chairman, my name is Michale Roush. I am the Chief Senate Legislative Representative for the National Federation of Independent Business. On behalf of NFIB and its more than 500,000 small business owner members, I appreciate the opportunity to participate in this committee's investigation into barriers to health care. The lack of availability of health care insurance is surely one of the barriers to health care. Small employers are increasingly reducing this barrier to adequate health care for themselves and their employers by providing employment based health insurance plans. Yet many policy makers, in their desire to make health insurance available to everyone, are in danger of creating new barriers to health care by imposing unrealistic requirements on small employers which will force them to drop existing health insurance plans. Without recognizing what the trends are in voluntary employee benefits and without recognizing what profitability and labor market realities face small employers policy makers' good intentions may become the next, and biggest, barrier to adequate health care. Consequently, my testimony focuses' on employer provided health insurance and on recently introduced legislation in that area (S. 2403).

In brief, I will argue that for the very large majority of small business owners in America, market forces ought to be allowed to operate in this product area. The goals of affordability, product quality, and broad coverage can best be ensured by insurance industry competition and informed consumer choice. The government should take the considerable role of ensuring that both of these conditions are met in our society. It is my hope that my testimony will both discourage overbearing government intervention and foster insurance industry competition, since the bulk of my statement consists of what might be called a small business market survey. If, however, public policy dictates that the government involve itself in the provision of health insurance, my testimony provides guidelines for making that involvement more effective and less expensive than it otherwise might be, at least, as far as small employers are concerned.

The National Federation of Independent Business is a voluntary membership organization comprised of more than 500,000 small business owner members. NFIB is primarily an advocacy organization, and our focus is primarily legislative. We represent the views of our members in the state capitals of all 50 states as well as before the federal government.

NFIB polls its entire membership to establish our position on public policy issues. The majority vote of the respondents becomes the position of NFIB. In addition, on issues of great complexity and/or interest to our members, we conduct -- or have conducted for as -- much more sophisticated and indepth surveys of our membership. Such surveys are recognized by the Small Business Administration and others as valid surveys of the small business community in general*.

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* William C. Dunkelberg and Jonathan A. Scott, Report on the Representatives of the National Federation of Independent Business Sample of Small Firms in the United States, Small Business Administration, 1984.

The following chart provides one indicator of why this is the case:

Profile of Small Business

	NFIB Membership by Industry	National Small Business Population by Industry
Retail	30%	31%
Service	28%	29%
Wholesale	8%	11%
Total Non-capital intensive	66%	71%
Manufacturing	13%	10%
Construction	13%	12%
Agriculture	5%	2%
Transportation	3%	4%
Total capital intensive	34%	28%

What follows in the next section of this testimony is based upon two such surveys. One, conducted in late 1978, is entitled National Health Insurance Report on Small Business; the other is entitled Small Business Employee Benefits, and was conducted in the latter part of 1985. The concluding part of this testimony is a discussion of the public policy recommendations NFIB would make based on the above material and our public policy polling results. As Appendix A I have included polling results in this area over the last ten years.

HEALTH INSURANCE AND SMALL BUSINESS.**

Sixty-five (65) percent of surveyed small business owners provided health insurance for at least a portion of their full-time employees. Approximately two-thirds (42%) carried it for all and one-third (23%) carried it for some. Provision was directly related to firm size--the larger the firm, the more likely it was to have employee health insurance. This relationship is clear whether firm size is measured in terms of employees (Table 2) or annual gross receipts (Table 3).

** See Appendix B on how the survey was conducted.

Table 1

PERCENT OF SMALL BUSINESSES PROVIDING SELECTED TYPES OF EMPLOYEE BENEFITS BY BENEFIT TYPE AND PERCENT OF FULL-TIME EMPLOYEES COVERED IN EACH FIRM

	PERCENT OF FULL-TIME EMPLOYEES COVERED IN EACH FIRM					
EMPLOYEE BENEFIT	None+	1-39%	40-60%	61-99%	100%	Total
Health Insurance	36	8	5	10	42	100%
Dental Insurance	84	2	1	2	11	100%
Retirement Plan	74	3	2	4	18	100%
Paid Vacations	23	7	3	8	59	100%
Paid Sick Leave	52	7	3	4	34	100%
Long-Term Disability	80	3	2	3	12	100%
Life Insurance	51	6	4	6	33	100%
Education Assistance	77	6	1	3	13	100%
Employee Discounts	61	2	2	3	32	100%
Flex-Time	82	8	3	2	7	100%
Paid Lunch Break	75	4	2	2	18	100%
Dependent Care	95	1	*	1	3	100%2Legal
Assistance	97	1	1	*	2	100%

Number of Respondents = 1,439

+ includes no answer
* less than 0.5%

+/ No answers can reasonably be interpreted as a random phenomenon or as a negative response. The former interpretation leads to distributing non-respondents proportionally across all answers; the latter interpretation leads to adding non-respondents to the negative column. The negative response interpretation was selected after reviewing individual questionnaires. It was evident from those documents that the intention of most non-respondents was to indicate a negative answer.

Table 2

PERCENT OF SMALL BUSINESSES PROVIDING THE MOST
COMMONLY PROVIDED EMPLOYEE BENEFITS BY
COMMON BENEFIT TYPE AND FIRM SIZE

	FIRM SIZE (FULL-TIME EMPLOYEES)							
MOST COMMON BENEFITS	1-4	5-9	10-19	20-49	50-99	100+	No Answer	Total
Paid Vacations								
Provided All	55	69	70	66	70	85	21	59%
Provided	18	18	22	27	29	16	5	18%
Not Provided	27	13	8	7	2	*	74	23%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Health Insurance								
Provided All	32	51	54	54	58	74	14	42%
Provided	17	28	29	34	36	15	9	23%
Not Provided	51	20	17	12	7	10	77	36%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Paid Sick Leave								
Provided All	35	37	38	36	32	49	12	34%
Provided	11	12	19	22	36	21	5	14%
Not Provided	54	51	43	42	32	31	83	52%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Life Insurance								
Provided All	21	39	46	41	56	80	14	33%
Provided	9	17	23	30	36	21	3	16%
Not Provided	70	44	30	29	9	*	83	52%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Employee Discounts								
Provided All	35	36	33	31	20	36	17	32%
Provided	7	6	10	8	12	3	5	7%
Not Provided	59	59	58	60	68	62	78	61%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Retirement Plan								
Provided All	9	16	28	31	54	56	6	18%
Provided	5	9	11	13	20	13	3	8%
Not Provided	86	76	61	57	26	31	91	74%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Number of Resp.	534	299	209	144	59	39	155	1439

* less than 0.5

Table 3

ANNUAL GROSS RECEIPTS OF SMALL BUSINESSES BY PERCENT OF FULL-TIME EMPLOYEES COVERED WITH EMPLOYER PROVIDED HEALTH INSURANCE (in percent)

ANNUAL GROSS RECEIPTS ($000's)	PERCENT OF FULL-TIME EMPLOYEES COVERED IN EACH FIRM					
	None+	1-39%	40-60%	61-99%	100%	Total
Less than 100	81	4	1	2	12	100%
100-199	59	7	5	7	23	100%
200-499	40	10	4	9	38	100%
500-799	26	10	4	13	47	100%
800-1,499	19	8	6	17	51	100%
1,500-2,999	8	7	8	14	63	100%
3,000-4,999	10	11	9	9	62	100%
5,000-9,999	11	4	4	13	70	100%
10,000 or More	6	4	4	17	70	100%
No Answer	38	8	6	9	40	100%
Percent of Respondents	36%	8%	5%	10%	42%	100%
Number of Respondents	517	110	66	149	597	1439

+ includes no answer

Benefits and Conditions

Hospitalization/surgical insurance covers those components of health care provided by a hospital and the "usual, customary, and reasonable" charges for surgical procedures performed. Major medical covers expenses beyond basic hospital and surgical benefits. And, a form of major medical known as comprehensive consists of major medical coverage "plus." These are the general types of health insurance (excluding such additions as dental) from which small employers can choose. Unfortunately, the comprehensive variation was inadvertently omitted from the questionnaire, limiting somewhat the analysis that could be performed on types of health insurance purchased by small business owners.

Over 80% of all respondents with health insurance reported carrying the most comprehensive benefit coverage listed on the survey, i.e. hospitalization/surgical and major medical (Table 4). Just 8% provided lesser coverage, and 10% either didn't reply or didn't know. There was some evidence that smaller firms were more likely to provide lesser kinds of coverage and vice versa, but the relationship was surprisingly weak.

Approximately one-third of those with health insurance did not provide it to all full-time employees. ("Non-discrimination" rules allow diffferent benefits or levels of benefits to be provided to different employee groups under specified conditions.) Table 5 reviews the conditions upon which some full-time employees were excluded from the plan. In almost half of the cases, a specified number of years on the job was the basis for inclusion/exclusion. (Later, the relationship between employee turnover and coverage will be visited.) Level of responsibility was the second most frequent point of distinction.

Eighty-six (86) percent provided an option for dependent coverage; just 3% indicated no dependent coverage was available. Those without dependent coverage tended to be among the smaller firms and vice versa. However, in no size class did the dependent coverage option fall below 74%. Only 8% of those carrying insurance provided part-time employees with the same health benefits as provided full-time employees. Virtually none provided a reduced level of coverage for part-time employees, illustrating the impracticality for most small businesses of carrying more than one coverage. Given the fact that 18% had no part-time employees, the number covered was actually higher than 8%. However, it is clear that comparatively few part-time employees working in small businesses received employer-sponsored health insurance benefits.

While the survey could not obtain more specific data on the level of health insurance provided, it appeared that once offered, the quality of insurance provided was reasonably uniform. There seemed to be little progression in benefit levels. In other words, a small business apparently did not initially offer minimal coverage, e.g., hospitalization only, and then move toward a better plan for benefit progression. Rather inclusion and exclusion of employees appeared to substitute. Though further evidence will be needed to confirm (or refute) this observation, temporarily assuming its accuracy, the second order question quickly becomes whether the employer decision is purposeful or whether insurance pricing is structured to force the decision.

Table 4
TYPE OF HEALTH INSURANCE PROVIDED SMALL BUSINESS EMPLOYEES
BY ANNUAL GROSS RECEIPTS OF SMALL BUSINESSES
(in percent)

	ANNUAL GROSS RECEIPTS ($000's)						
INSURANCE TYPE	Under 200	200-799	800-1,499	1,500-4,999	5,000 or More	No Answer	Total
Hospitalization/ Surgical	2	4	4	2	2	3	3%
Major Medical	8	4	6	5	4	6	5%
Hospitalization/ Surgical and Major Medical	78	79	80	88	88	76	82%
Don't Know/No Answer	13	13	10	6	10	15	10%
Total	100%	100%	100%	100%	100%	100%	100%
Number of Resp.	120	312	159	198	100	33	922

NA A few large small businesses reported both voluntary and compulsory benefit levels that were considerably "out-of-range." While there is no question of the data's authenticity, additional work is required before they can be reported. Until then, the maximum allowable cost for purposes of calculating an all firms average is $9,999 per month.

Table 5

SELECTED CONDITIONS OF EMPLOYEE HEALTH
INSURANCE COVERAGE BY INDUSTRY
(in percent)

SELECTED CONDITIONS	INDUSTRY										
	Con	Mfg	Trn	Whl	Ret	Agr	Fin	Ser	Prf	N/A	Total
Basis for Coverage+											
Years on the Job	22	13	11	6	15	28	6	14	9	29	14%
Certain Wage or Salary Level	3	2	3	2	4	6	*	7	*	14	3%
Age	*	2	*	1	2	3	3	3	*	14	2%
Level of Responsibility	8	4	11	5	10	14	3	7	3	43	7%
Other	7	3	8	5	4	*	10	8	5	*	5%
None	60	76	67	81	65	49	78	61	83	*	69%
Option for Dependent Coverage											
Yes	86	92	87	89	82	72	91	79	91	86	86%
No	1	1	*	2	6	11	1	7	5	*	3%
No Answer	13	7	13	9	12	17	7	14	5	14	11%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Part-Time Employee Coverage											
No Part-Time Employees	32	23	32	17	9	11	16	22	11	14	18%
No Coverage	27	41	32	42	46	50	30	46	41	57	40%
Less Coverage Than Full-Time	*	3	*	2	1	*	*	1	*	*	1%
Same Coverage As Full-Time	8	4	3	6	10	8	10	9	20	*	8%
No Answer	34	30	34	34	35	31	44	22	29	29	33%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number of Resp.	120	155	38	103	226	36	81	90	66	7	922

+respondent could mark more than one answer
* less than 0.5%
N/A no answer

Trends in Coverage

Health insurance coverage appears to be increasing in the nation's small businesses, though the proportion of small business employees covered remains significantly less than the proportion covered in large and mid-sized enterprises. The 65% of responding small business owners now reporting at least some full-time employee coverage (See Table 2) represented an eight percentage point increase from 1978 when a similar survey reported 57% coverage.*/ The retail, finance, and professional services industries were largely responsible for the rise (Table 6). All three industries experienced increases from the 1978 survey of more than 10 percentage points. Transportation/Communication also appeared to have experienced a considerable increase, but the sector's small sample size (n=37 and n=53) allowed no conclusions. The troubled agricultural industry was the only sector which reduced coverage over the period.

Since the retail, finance, and professional service industries tend to consist of firms smaller than average, the increased number of firms now providing employee health insurance can also be tied to greater coverage among smaller firms. Unfortunately, a direct comparison of coverage by firm size as measured in annual gross receipts is almost meaningless. With the Consumer Price Index having risen by 66% over the period, inflation has changed the value of a specified level of gross too much to compare response classes. However, it can be observed that the largest firms were no more inclined to provide health insurance in 1985 than they were in 1978, and perhaps even a little less. By elimination, the smallest firms then were those left to account for the greater coverage.

The overall quality of health insurance plans, i.e. coverages, costs, deductibles, etc. appeared to have also changed. Unfortunately, a comparison between quantity (number with plans) and quality (composition of plans) is difficult at best, but it is exacerbated by the data available. Quantity for present purposes was measured over a seven-year interval employing two different surveys. Quality was measured over a three-year interval employing one survey and the recall of respondents. Complicating matters, changes in the first four years were probably significantly different from those in the last three.

Despite these data limitations, small business owner responses in 1985 suggested considerable change in the characteristics of health benefits provided over the past three years, though on balance only modest improvement (Table 7). For example, the number increasing the percentage of employees covered was three times as great as the percentage decreasing. Benefits were increased by 26% compared to 14% reducing them. But the size of deductibles rose in 38% of the cases; co-insurance requirements rose as well. Costs (premiums) for both employers and employees rose, but employers were far more likely to have experienced one. In fact, three of four reported their premium cost higher than three years prior, but just one of four reported the employee premium cost higher. As many as 36% failed to respond to aspects of change in health insurance coverage. Since only responses from those with coverage three years ago were counted, it would appear that many owners were not familiar with the details of the plan they provide.

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*/ National Health Insurance Report for Small Business (National Federal of Independent Business: San Mateo, CA), June, 1978.

Table 6

PERCENT OF SMALL BUSINESSES PROVIDING
EMPLOYEE HEALTH INSURANCE BY
INDUSTRY - 1978 AND 1985

INDUSTRY	YEAR 1978	YEAR 1985	PERCENT CHANGE 1978-1985
Construction	66	73	+11
Manufacturing	81	83	+2
Transportation	60	73	+22
Wholesale	73	73	0
Retail	46	58	+26
Agriculture	52	48	-8
Financial Services	56	65	+16
Services	48	52	+8
Professional Services	49	62	+27
ALL FIRMS	57%	65%	+14

Table 7

PERCENT OF SMALL BUSINESSES EXPERIENCING
CHANGES IN EMPLOYEE HEALTH INSURANCE
COVERAGE OVER PAST THREE YEARS
(Excluding firms not in business or without
coverage three years ago)

	HEALTH INSURANCE CHANGES				
COVERAGE	Decrease	No Change	Increase	No Answer	Total
Percent of Employees	5	53	20	22	100%
Benefits	14	39	26	21	100%
Premium Cost (employer's)	4	6	75	16	100%
Premium Cost (employee's)	2	38	27	33	100%
Deductibles	4	35	38	23	100%
Co-Insurance Requirements	1	52	11	36	100%

Number = 828

Costs

It is not news that health insurance premiums are expensive. The average firm purchasing insurance spent approximately $1,750 per month for coverage--more than double the sum spent in 1978 (Table 8). (Health care costs rose 84% over the period.) Moreover, health insurance premiums amounted to a substantial portion of the total cost of an employee's benefit package. Compare the data on Table 8 to the data on Table 9. Note that the mean monthly health insurance cost was $1,766 and the estimated mean monthly benefit cost was $2,392. That implies health insurance accounted for nearly 75% (in costs) of total voluntary benefits provided. That comparison can be misleading, however. The potential for deception is best illustrated in the less than $100,000 annual gross receipts classification where the health premiums were larger than the total amount of voluntary benefits. The reason was that the total benefit figure was based on the 938 respondents; the total health premium figure was based on the 794 respondents. Nevertheless, it is clear that health insurance costs constituted a very large share of a small business's employee benefits package no matter how it is measured.

Table 10 places these health insurance cost figures in a more understandable form. The median (50% above-50% below) small employer cost of insurance per employee lay between $75 and $99 per month. However, the average was drawn higher due to the nearly 20% absorbing a monthly cost of $150 or more. The median cost per employee with dependent coverage amounted to somewhat more than $125.

Part of the reason small employers faced such large health insurance costs was that more than 2/3 paid the entire premium, and a whopping 87% paid more than half (Table 11). (Both figures cited adjust for the 10% no answer.) Curiously, 72% of those with insurance and annually grossing $100,000-$199,999 picked up 100% of the premium (over 80% adjusting for no answer). The figure fell into the 60's among those firms grossing $200,000 to $4,999,999, then into the 40's among firms grossing more than $5,000,000. This somewhat surprising distribution may be the result of administrative costs and bother in deducting the employee's share when few employees are affected; wages can be adjusted more easily. It also might reflect an emulation by small businesses with greater than 50 employees of large and medium sized enterprises where the trend has been toward a reduced employer share.

Table 8

MEAN MONTHLY EMPLOYER HEALTH INSURANCE PREMIUMS COSTS BY SMALL BUSINESS BY ANNUAL GROSS RECEIPTS AND SMALL BUSINESS INDUSTRY - 1978 and 1985

1978 ANNUAL GROSS ($000's)	1978 Mean Monthly Premium	1985 Mean Monthly Premium	1985 ANNUAL GROSS ($000's)
Under 50	$ 167		
50-99	$ 168	$ 460	Under 100
100-199	$ 327	$ 383	100-199
200-349	$ 396		
		$ 718	200-499
350-799	$ 558		
		$ 974	500-799
800-1,499	$ 958	$1,137	800-1,499
1,500 or More	$2,268		
		$2,435	1,500-2,999
		$3,134	3,000-4,999
		$4,871	5,000-9,999
		NA	10,000 or More
ALL FIRMS	$ 838	$1,766	ALL FIRMS

INDUSTRY	1978 Mean Premium	1985 Mean Premium	Percent Change 1978 to 1985
Construction	$ 868	$1,492	72%
Manufacturing	$1,805	$3,552	97%
Transportation	$ 538	$1,624	202%
Wholesale	$ 833	$1,898	128%
Retail	$ 504	$1,090	116%
Agriculture	$ 677	$1,426	111%
Financial Service	$ 836	$1,346	61%
Services	$ 541	$1,469	172%
Professional Service	$ 451	$1,445	200%
ALL FIRMS	$ 838	$1,766	111%

NA A few relatively large businesses reported health insurance premiums that were considerably "out of range." Treatment of these data is outlined in Table 9.

Table 9

ESTIMATED MEAN EMPLOYER COST OF VOLUNTARY BENEFITS AND HEALTH INSURANCE BY SMALL BUSINESS ANNUAL GROSS RECEIPTS

ANNUAL GROSS RECEIPTS ($000's)	Mean Monthly Cost of Voluntary Benefits	Number	Mean Monthly Cost of Health Insurance	Number	Per Firm Health Insurance As A % of All Voluntary Benefits[1]	Population Health Insurance As A % of All Voluntary Benefits[2]
Under 100	$ 348	64	$ 460	30	132%	62%
100-199	$ 701	110	$ 383	78	55%	39%
200-499	$1,074	190	$ 718	154	67%	34%
500-799	$1,469	128	$ 974	107	66%	55%
800-1,499	$2,081	144	$1,137	148	55%	---
1,500-2,999	$3,748	120	$2,435	117	65%	63%
3,000-4,999	$4,397	60	$3,134	55	71%	65%
5,000-9,999	$6,291	48	$4,871	40	77%	64%
10,000 or More	NA	47	NA	40	---	---
No Answer	$2,707	27	$2,080	25	77%	71%
ALL FIRMS	$2,392	938	$1,766	794	74%	63%

[1] Calculated by dividing the mean monthly cost of health insurance by the mean monthly cost of voluntary benefits.

[2] Calculated by dividing the sum of health insurance costs in each size class (not shown) by the number in each size class reporting a voluntary benefits cost. The result was divided by the mean monthly employer cost of voluntary benefits.

NA A few large small businesses reported both voluntary and compulsory benefit levels that were considerably "out-of-range." While there is no question of the data's authenticity, additional work is required before they can be reported. Until then, the maximum allowable cost for purposes of calculating an all firms average is $9,999 per month.

Table 10

PERCENTAGE DISTRIBUTION OF EMPLOYERS' COSTS IN PROVIDING HEALTH INSURANCE FOR INDIVIDUAL EMPLOYEES AND DEPENDENTS

	Individual Employee			Employee and Dependents	
EMPLOYER'S SHARE OF MONTHLY PREMIUM PER EMPLOYEE	Total	Total-N/A Excluded	EMPLOYER'S SHARE OF MONTHLY PREMIUM PER EMPLOYEE	Total	Total-N/A Excluded
$ 0-9	1	2	$ 0-24	9	11
$ 10-24	2	3	$ 25-49	3	4
$ 25-49	10	13	$ 50-74	8	10
$ 50-74	20	26	$ 75-99	7	9
$ 75-99	16	20	$100-124	10	13
$100-124	8	11	$125-174	17	23
$125-149	5	6	$175-224	12	15
$150 or more	15	19	$225 or more	11	14
No Answer	23	--	No Answer	23	--
TOTAL	100%	100%	TOTAL	100%	100%
Number of Resp.	992	713	Number of Resp.	922	706

Table 11

ANNUAL GROSS RECEIPTS OF SMALL BUSINESSES PROVIDING EMPLOYEE HEALTH INSURANCE BY EMPLOYEE SHARE OF HEALTH INSURANCE PREMIUM

(in percent)

	EMPLOYEE PREMIUM SHARE							
ANNUAL GROSS RECEIPTS ($000's)	None	1-24%	25-49%	50-74%	75-99%	100%	No Answer	Total
Under 100	63	9	6	6	*	*	17	100%
100-199	72	8	4	2	1	1	11	100%
200-499	62	5	8	10	*	2	13	100%
500-799	64	8	9	3	1	3	11	100%
800-1,499	62	9	10	8	1	1	8	100%
1,500-2,999	67	9	7	10	2	1	5	100%
3,000-4,999	63	9	8	9	2	2	8	100%
5,000-9,999	44	10	20	14	*	*	12	100%
10,000 or More	44	12	14	18	*	2	10	100%
No Answer	46	12	15	6	*	3	18	100%
Percent of Resp.	62%	8%	9%	9%	1%	1%	11%	100%
Number of Resp.	567	76	83	78	7	13	98	922

* less than 0.5%

Carriers and Sponsors

A majority (53%) of small business owners carried their health insurance with a private carrier other than Blue Cross/Blue Shield (Table 12). From the comparatively few respondents specifying one of these carriers, the Travelers appeared to serve the largest number. The "Blues" carried 24%. Self-insurance (4%) and HMO's (3%) remained an oddity. Sixteen (16) percent did not respond. With the exception of self-insurance, which naturally was confined to those with $5 million or more in annual gross receipts, the carrier seemed unrelated to either industry or firm size.

The firm itself was the most frequent group sponsor (45%), followed by trade or business associations (27%) (Table 12). But among some industries, there was a far greater propensity to have association, sponsored plans than among others. For example, owners of professional service and financial service firms procured their employee health insurance through trade associations with twice the frequency as did owners of manufacturing and agricultural firms (Table 13). No immediate explanation for these differences was apparent. The most obvious, firm size which was directly related to industry, showed no relationship to group sponsor. The comparative strength or marketing capacity of varying trade groups may provide the answer, but the survey did not collect information regarding association membership.

Table 13 provides evidence of a major shift in group sponsors over the past seven years. The trade association has been increasing in importance at the direct expense of the individual firm. In fact, proportionately distributing no answers as was done on Table 13, the net increase in firms providing health insurance was almost identical to the net increase in the number of firms with an association sponsor. But the results were mixed when assessing whether or not the trend toward trade associations as sponsors has been a factor in increasing insurance coverage in those industries principally responsible for the overall small business increase. Recall that it was growth in the financial services, professional services and retail as well as smaller firms that were largely responsible for the increase in the number of firms covered between 1978 and 1985. Neither the retail nor the financial services industries shifted group sponsorship to to the degree the total population did. Professional services, however, showed the most radical shift to association sponsorship (19 percentage points). Unfortunately, a comparison with 1978 could not be made since that data could not be recaptured. Another piece of data -- the reduced incidence of smaller firms citing an inability to obtain group insurance -- also suggests that trade associations may have been helpful to the smallest firms.

Table 12

INSURANCE CARRIER OF SMALL BUSINESSES PROVIDING EMPLOYEE HEALTH INSURANCE BY GROUP SPONSOR
(in percent)

	GROUP SPONSOR					
INSURANCE CARRIER	Firm	Trade Assoc.	Self-Insured	Other	No Answer	Total
HMO	4	2	3	*	2	3%
Self-Insured	1	4	46	*	2	4%
Blue Cross/ Blue Shield	31	26	14	9	12	24%
Other Private	60	65	37	87	24	53%
No Answer	4	4	*	4	61	16%
Total	100%	100%	100%	100%	100%	100%
Number of Resp.	414	251	35	23	199	922

* less than 0.5%

Table 13

PERCENTAGE DISTRIBUTION AND CHANGE IN DISTRIBUTION OF GROUP SPONSORING SMALL BUSINESS EMPLOYEE HEALTH INSURANCE - 1978 AND 1985

	YEAR		PERCENT CHANGE
GROUP SPONSOR	1978*	1985@	1978-1985
Firm	70	57	-19
Trade Association	25	35	+40
Construction	(23)	(36)	(+57)
Manufacturing	(11)	(21)	(+91)
Transportation	(33)	(37)	(+12)
Wholesale	(24)	(40)	(+67)
Retail	(33)	(36)	(+ 9)
Agriculture	(19)	(25)	(+32)
Financial Services	(43)	(47)	(+ 9)
Services	(29)	(30)	(+ 3)
Professional Services	(33)	(52)	(+58)
Other	5	8	+60
TOTAL	100%	100%	--

* estimated from data in 1978 report
@ distributing a 22% no response
( ) subtotals

Satisfaction With Insurance

Almost 2/3 (66%) of the small employers providing at least some health insurance coverage were generally satisfied with the plan made available to their employees (Table 14). While at first blush a 66% satisfaction rating would seem favorable, it was 16 percentage points lower than the 1978 evaluation. The change from 1978 should not be surprising given the very large increases in premiums paid (see Table 9). Note, for example, that the percent indicating "not satisfied, but can't afford a better plan" rose seven percentage points over the period. In addition, Table 15 shows that those with less costly plans were more often satisfied than were those with more expensive plans.

Satisfaction appeared unrelated to either the plan carrier or the group sponsor. But as expected, satisfaction was related to the amount of time spend investigating health insurance options, health care cost reduction alternatives, etc. The more dissatisfied the small business owner was with his insurance, the more time he spent looking for alternatives. However, a variety of factors intervened to reduce the strength of the satisfaction/search relationship.

Table 14

PERCENTAGE DISTRIBUTION OF SMALL BUSINESS OWNER SATISFACTION WITH EMPLOYEE HEALTH INSURANCE - 1978 AND 1985

	YEAR	
SATISFACTION	1978	1985
Generally Satisfied	82	66
Not Satisfied, Can't Afford Better	9	16
Not Satisfied, Soon Will Have Better	2	3
Soon Will Reduce Coverage	*	1
Soon Will Drop Coverage	N/A	*
Subject to Union Agreement	3	2
No Answer	4	11
TOTAL	100%	100%

* less than 0.5%
N/A not asked

Table 15

SMALL BUSINESS OWNER SATISFACTION WITH EMPLOYEE HEALTH INSURANCE PLAN BY EMPLOYER'S COST
(in percent)

	EMPLOYER'S COST PER INDIVIDUAL ($'s)					
SATISFACTION	Less Than 50	50-99	100-149	150 or More	No Answer	Total
Generally Satisfied	78	76	66	65	44	66%
Not Satisfied, Can't Afford Better	19	16	21	18	11	16%
All Others	2	5	7	15	6	6%
No Answer	*	4	6	2	39	11%
Total	100%	100%	100%	100%	100%	100%
Number of Respondents	127	330	122	134	209	922

* less than 0.5%

Searching for Health Care

Small business owners are busy people; their time is often their greatest asset. Thus, it should not be startling that few small business owners personally spent much time searching for health insurance options, means to control health care costs, etc. But it is startling that neither they nor a designated employee spent much time considering options to the rapidly escalating cost of health insurance and health care.

The median time spent (owner or designated employee) investigating health care options within the last 12 months was about four hours or one-half day (Table 16). Clearly, those that had coverage spent more time than those who did not, but not by the margin one might have expected. Moreover, those covering a greater proportion of full-time employees did not spend appreciably more time than did those covering a lesser proportion.

The most noticeable cell on Table 16 is the one indicating that 41% of those without insurance spent less than one hour within the last year looking at health care options. This group probably consisted for the most part of those not interested in locating coverage. But, there were also many who spent a reasonable time searching and simply could not find something to meet their needs.

The amount of time spent searching was clearly reduced by the dependence on outside advisors. In the overwhelming majority of instances (over 60%), small business owners relied on outside professionals to provide them information on health insurance and health case costs, options, etc. The single most important source of that information, and by overwhelming margins, was the insurance agent. Forty-four (44) percent of all respondents cited this source, followed by trade associations (16%), insurance brokers (15%), magazines/publications (4%), health care providers (2%), business consultants (2%), and other (1%); 16% did not respond (Table 17). Curiously, the amount of owner/employee time spent searching increased with reliance on brokers and consultants, but decreased with reliance on agents. The opposite would have been expected. Brokers and consultants effectively become employees when engaged for certain purposes; their incentive is to reduce client costs. The incentive for agents is somewhat different.

Table 16

SMALL BUSINESS OWNER OR EMPLOYEE HOURS SPENT INVESTIGATING HEALTH CARE OPTIONS IN LAST 12 MONTHS BY PERCENT OF FULL-TIME EMPLOYEES COVERED IN EACH FIRM
(in percent)

HOURS SPENT IN LAST 12 MONTHS INVESTIGATING	PERCENT OF FULL TIME EMPLOYEES COVERED IN EACH FIRM					
	None+	1-39%	40-60%	61-99%	100%	Total
Less Than One	41	28	24	13	19	27%
1-4	14	19	18	20	20	18%
5-8	9	16	15	18	14	13%
9-16	5	13	12	17	13	11%
17-24	2	3	5	4	7	4%
25-40	3	6	11	11	8	7%
41-80	1	4	5	7	6	4%
81 or More	*	2	*	1	5	3%
No Answer	25	11	11	9	6	14%
Total	100%	100%	100%	100%	100%	100%
Number of Resp.	517	110	66	149	597	1439

* less than 0.5%
+ includes no answer

Table 17

MOST IMPORTANT HEALTH COST INFORMATION SOURCE FOR SMALL BUSINESS OWNERS BY HOURS SPENT INVESTIGATING HEALTH CARE OPTIONS IN LAST 12 MONTHS
(in percent)

MOST IMPORTANT INFORMATION SOURCE	HOURS SPENT INVESTIGATING IN LAST 12 MONTHS						
	Less Than One	1-4	5-8	9-16	17 or More	No Answer	Total
Insurance Agent	51	55	54	47	42	10	44%
Insurance Broker	7	15	19	24	30	3	15%
Trade Association	18	21	15	16	16	4	16%
Health Care Providers	3	1	4	1	2	2	2%
Magazines/ Publications	5	4	3	4	4	1	4%
Business Consultant	1	*	2	3	4	1	2%
Other	2	*	*	1	1	*	1%
No Answer	13	3	2	4	1	80	16%
Total	100%	100%	100%	100%	100%	100%	100%
Number of Resp.	395	256	184	152	255	197	1439

* less than 0.5%

Minimum Coverage Requirements

At least 20 states now require that any business providing employee health insurance include minimum levels of coverage for particular health conditions. For example, Massachusetts mandates that employer based health insurance include certain levels of mental health coverage. While still reasonably new, a question arises on the impact or influence of such public policy given that economic causes are frequently cited for non-coverage.

Table 18 illustrates that comparatively few small employers recognized that minimum coverage requirements exist. Just 6% reported their state had such requirement; 26% didn't know if their state did or not. Grouping the states with minimum coverage and those without, then distributing the small business population among them, the percent recognizing the requirement was only a fraction of those to which it applied and for which they were paying. The reason so few recognized those minimum coverage requirements is obvious. The additional coverage is wrapped in the new policy and given to the small business owner on a "take it or leave it" basis.

Of the 6% recognizing minimum coverage requirements, two of three indicated they did not change coverage in response. The next largest group expanded coverage to comply, with only a smattering claiming to have either shifted or dropped coverage. But the sample numbers are far too small to make any generalizations.

Table 18

PERCENTAGE DISTRIBUTION OF SMALL BUSINESS OWNER AWARENESS OF AND CONSCIOUS RESPONSES TO STATE MINIMUM COVERAGE REQUIREMENTS

MINIMUM CHANGE REQUIREMENTS	AWARENESS OF REQUIREMENTS	CONSCIOUS RESPONSES
Yes	6	
No Change in Coverage		66
Coverage expanded		22
Shifted Coverage		4
Dropped All Coverage		1
Doesn't Affect Me		1
No Answer		6
Subtotal		100%
No	68	
Don't Know	26	
TOTAL	100%	

Non-Coverage

Despite the increased number of small business owners providing employee health insurance, over one-third provided none; others did not provide it for all employees. The reason(s) for pursuing the no insurance option were neither surprising nor irrational. While no single reason dominated, almost all fell under the general headings of work force composition or cost.

"Generally covered under a spouse or parent policy" was the single most frequently given reason (29%) (Table 19). In other words, the employee mix consisted of significant proportions of secondary wage earners. Covering this group presumably increases labor costs without providing any additional benefits to employees. Table 19 reveals that the secondary wage earner issue was the primary reason firms with coverage often did not include all employees in the benefit. "Employee turnover too great," a second labor force composition reason, was more frequently cited by larger employers (Table 20). Recall that in the previous discussion of benefit conditions, employee tenure was the most frequently used method to separate eligibility for health insurance benefits where such separation existed (Table 4).

It was often a simple matter of economics for employers who provide no health insurance. Half of those without insurance either attributed their action to premiums being too high (33%) or to insufficient profitability (20%)--opposite sides of the same proposition. Not surprisingly, these economic reasons were most pronounced among those with coverage for no full-time employees.

Another 19% said the firm could not qualify for group coverage, which implies another variant of the cost problem. The inability to qualify as a group (real or perceived) was focused among the respondents employing 1-4 people (Table 21). Sixteen (16) percent of the very smallest employers cited it. Moreover, almost all who believed they could not qualify for group coverage indicated the reason was business size.

Despite additional response categories in the 1985 survey, the distribution of reasons for not having employee health insurance in 1985 was similar to distribution in 1978. The two reasons most frequently cited in 1978 were the two most frequently cited in the current survey. A nuance in this regard was that those attributing their action to a predominance of secondary wage earners fell twelve percentage points to 26%. There is no immediate explanation for the fall. Small declines were also registered for employee turnovers and can't qualify for a group.

Given the reasons for not currently providing employee health insurance, stimulants to provide it were predictable. Lower rates and greater profitability were the two most frequently noted (Table 21). "Business got bigger," "qualify as a group," and "employees asked for it" followed at a distance. Just 4% of those not providing coverage for all full-time employees, or 3% of the entire sample, indicated they would not provide health insurance under almost any circumstance. That is about the same as the number providing the identical response in 1978.

Table 19

SMALL BUSINESS OWNER REASONS NOT TO PROVIDE HEALTH INSURANCE TO ALL FULL-TIME EMPLOYEES BY PERCENT OF FULL-TIME EMPLOYEES COVERED IN EACH FIRM

(in percent)

	PERCENT OF FULL-TIME EMPLOYEES COVERED IN EACH FIRM				
REASON	None+	1-39%	40-60%	61-99%	Total*
Premiums Too High	33	29	14	7	27%
Employee Turnover Too Great	15	21	18	8	15%
Generally Covered Under A Spouse or Parent Policy	26	29	33	26	29%
Never Thought About It	2	*	*	*	1%
Administrative Expenses Too High	8	5	2	1	6%
Employees Prefer Compensation	8	10	6	5	8%
Firm Insufficiently Profitable	20	10	11	2	15%
Can't Qualify For Group Policy	19	4	2	2	12%
Other	4	7	*	4	4%
Total@	135%	115%	86%	55%	117%
Number of Respondents	517	110	66	149	842

+ includes no answer
* less than 0.5%
@ respondents could mark more than one answer

Table 20

SMALL BUSINESS OWNER REASONS NOT TO PROVIDE HEALTH INSURANCE TO ALL FULL-TIME EMPLOYEES BY FIRM SIZE

(in percent)

	FIRM SIZE (FULL-TIME EMPLOYEES)						
REASON	1-4	5-9	10-19	20-49	50+	No Answer	Total@
Premiums Too High	32	32	30	21	11	14	27%
Employee Turnover Too Great	16	16	15	24	26	7	15%
Generally Covered Under A Spouse or Parent's Policy	33	32	40	23	14	11	29%
Never Thought About It	2	*	*	*	*	2	1%
Administrative Expenses Too High	7	6	5	3	6	4	6%
Employees Prefer Compensation	7	10	10	9	6	4	8%
Firm Insufficiently Profitable	20	12	9	6	9	13	15%
Can't Qualify For Group Policy	16	5	6	2	*	18	12%
Other	2	1	3	9	11	10	4%
Total@	135%	114%	118%	97%	83%	83%	117%
Number of Respondents	365	146	97	66	35	133	842

* less than 0.5%

@ respondents could mark more than one answer

Table 21

CAUSES FOR SMALL BUSINESS OWNERS TO PURCHASE HEALTH INSURANCE FOR ALL FULL-TIME EMPLOYEES BY PERCENT OF FULL-TIME EMPLOYEES COVERED IN EACH FIRM
(in percent)

	PERCENT OF FULL-TIME EMPLOYEES COVERED IN EACH FIRM				
CAUSE TO PURCHASE	None+	1-39%	40-60%	61-99%	Total@
Qualify as a Group	16	5	*	3	11%
Business Became More Profitable	24	23	11	4	23%
Rates Were Lower	36	23	17	9	28%
Minimum Coverage Requirements Dropped	5	5	2	1	4%
Rates and Coverages More Stable	8	5	3	2	6%
Business Got Bigger	19	11	6	3	14%
More Difficult to Find Good Employees	6	6	6	3	6%
Employees Asked For It	10	15	3	8	9%
Wouldn't Provide Under Almost Any Circumstance	5	3	2	1	4%
Total@	129%	96%	50%	34%	105%
Number of Respondents	690	105	32	44	871

+ includes no answer
* less than 0.5%
@ respondents could mark more than one answer

Concluding Observations

The survey did not (and probably could not) obtain data on the level of health insurance benefits provided. However, the evidence available suggests that benefits are surprisingly consistent or uniform given the varying conditions of the small businesses and small business owners surveyed. For example, almost all providing insurance carried hospitalization/surgical and major medical; virtually none provided lesser degrees. Similarly, virtually all had a dependent care option. While a broad distribution of monthly per employee costs was apparent, arguing against a uniformity thesis ("you get what you pay for"), the principal distinction seemed to occur between those employees covered and those employees not covered. Recall that no employees were offered health insurance in 36% of the firms and only selected employees were offered health insurance in 23% of firms. Given those conditions and the economic reasons many small employers gave for not offering health insurance, it is curious that the distribution of benefits is not much greater than it appears. This situation raises two related points. The first is whether the employer's decision to provide "all or nothing" coverage is purposeful or whether insurance pricing is structured to force a decision. The second is that public policy actions to include minimum coverage requirements serve to increase the gap between those covered and those not covered.

The dependence on outside advisors for health-related matters appears unusually high given the costs involved. Assuming these appearances are not deceiving, an entire series of questions then arise. For example, why is more responsibility delegated on health care to an "outsider" than it probably is on other purchasing decisions? Is it to the owner's and/or employees' benefit? What effect does it have on coverage patterns? This survey was not intended to answer such questions, but they are important ones that need to be addressed at some point.

There is no reason to expect a significant increase in the number of firms providing employee health insurance such as the one experienced between 1978 and 1985. However, some rise might be expected. On the plus side, reductions in health care cost increases should translate into more reasonable insurance costs (though they still are rising faster than inflation). A second plus is that trade associations show every sign of maintaining, if not increasing, their insurance-related activities. Association activity should continue to provide smaller and often less affluent firms access to group coverage. The third factor is that health insurance is increasingly accepted as a condition of employment; the market from this perspective is pushing greater direct coverage. But on the negative side, small business profitability was high in 1978 and reasonably high in 1985 (it peaked about a year and one-half earlier). It is doubtful similar favorable economic conditions can stimulate much broader coverage. Poorer conditions could do the opposite. In addition, there will always be differences in profitability, meaning there will always some firms with an affordability problem. Those negative reasons are on top of the employee related causes for not providing insurance. With the increasing use of part-time labor and secondary wage earners, the incentive to provide health insurance is declining; the market from this perspective is promoting less direct coverage. Thus, there are cross-currents which will influence small business owners' decisions on health care. On balance, these factors point to greater coverage, but not much greater.

POLICY RECOMMENDATIONS AND CONCERNS:

General

Based on the foregoing information and on our policy polls (Appendix A), the National Federation of Independent Business is opposed to any program of compulsory national health insurance, including one covering catastrophic illness only. The vast majority of Americans are protected by voluntary private insurance programs or already existing government programs. Furthermore, an increasing percentage of American firms are voluntarily providing substantial health insurance benefits to their employees. The need for such an intrusive policy on the part of the federal government seems to be minimal; indeed, this seems to have been generally accepted lately, since the public policy debate is no longer focused on broad mandatory national requirements but rather on trying to address the specific problems of limited portions of the population, e.g., those with existing medical problems, self-employed, children, unemployed persons, and others desirous of being insured but unable to afford it. This has been a generally positive turn of events and one which NFIB finds encouraging. However, in the attempt to target policy to such groups Congress and the states must be careful not to create new gaps by discouraging (because of mandated cost increases or unrealistic administrative demands) the increase in voluntary employer sponsorship of health plans. In short, we are happy to assist this committee, or anyone else, with information about the characteristics of small firms in this country which might assist in a market oriented solution to closing the health insurance coverage gap.

While an increasing percentage of small business owners provide employee health insurance, it would be unrealistic to expect, and unwise in the extreme to mandate, 100% coverage of all small business employees in the country. There are too many factors which neither the government nor the small business owner can control which mitigate against such an expectation or such a mandate. Such things as high employee turnover, the large percentage of secondary wage earners working for small businesses, and the variable profitability of firms are all beyond the control of reasonable policy. Nevertheless, some of the reasons currently given for non-coverage may be amenable to policy changes. That the firm can't qualify for a group policy or that premiums are too high may bear investigation. Let me first consider the limiting conditions.

Employee turnover in small businesses is high, although layoffs appear relatively low except in the construction industry. This is the result of numerous factors, including heavy utilization of teenagers, seasonal help, generally lower wage scales, etc. In fact, the NFIB Quarterly Economic Report for Small Business consistently finds approximately one in ten small firms has a net decrease in employment every quarter, with an average of three to four employees per firm. While these data do not capture the extent of turnover because they measure only decreases among firms registering net decreases in total employment, they are indicative of the situation. Corroborative indications of high employee turnover can be found in two additional pieces of data: 1) 38% of all small employers register as a common complaint about job applicants that they will not stay long; and, 2) 15% of those small firms not carrying employee health insurance indicate high employee turnover as a reason for not doing so.

Secondary wage earners are a very large portion of the small business labor force. NFIB estimates that 80% of all teenagers working are now employed by small firms. While all teenagers are not secondary wage earners, they are far more frequently secondary wage earners than adults. In all size categories of businesses, the single biggest reason for not providing health insurance to all employees was that their employee mix consisted of significant numbers of people generally covered under a spouse's or parent's policy.

Profitability is a problem for every business entity, but particularly so for the very smallest firms, which are often start-ups. There are large numbers of marginal small businesses that simply cannot afford to increase fixed costs by offering health insurance benefits to employees. We find that the median money income of self employed persons is lower than the median money income for the population as a whole. The assumption, therefore, that all firms are capable of taking on such an additional fixed cost simply isn't valid. Looking back to tables number 2 and number 20, in the size categories 1 to 4 and 5 to 9, I believe demonstrates this point quite vividly. It is in these size categories where lack of profitability is a significant reason for not offering health insurance, and they are also where we see the largest gap in coverage.

The above three factors taken together must obviously limit one's expectations about the ability of small firms to provide health insurance for employees. They also are limitations to federal or state policy in this area. The following are some of those policy limits:

First, a period of employer paid insurance benefits beyond job termination is unreasonable. It is conceivable, under some of the proposals I have seen, that a small employer could pay for an employee's insurance for more than twice the number of days that individual was employed (e.g., assume insurance eligibility after one month's employment and coverage termination three months after separation). This situation opens the door to all kinds of abuse and serves as an incentive for movement in and out of the labor force. More importantly, however, it would generate considerable paperwork and unnecessary premium payments. For example, if a separated employee immediately accepted another job unbeknownst to the original employer, both employers could be paying premiums on the same individual. Furthermore, those employers without computerized payroll systems, i.e. most small employers, would find themselves filing and re-filing with their insurance companies as well as rearranging their bookkeeping procedures to ensure that a separated employee is removed from the covered list as soon as legal.

Second, any program that required coverage for seasonal employees -- those that are hired for a specified period of time, like the Christmas season or for the summer -- would be a mistake. In such short term employment situations it is recognized by both parties that the employment is temporary and not necessarily subject to the identical pay or benefit conditions of those employed full time. If such employees were required to be covered by statute, the incentive would be for employer to reduce the number of jobs for teenagers, particularly, by having existing employees work overtime, or by developing some "three weeks working and one week not working" mechanism to avoid the system, or by doing without -- none of which would be beneficial to the employees or the employers.

Third, unless consideration is given to the problem of double coverage (beyond that already cited) resulting from the large proportion of secondary wage earners in the small business labor force, any nationally mandated program would be terribly wasteful and unnecessarily expensive. For example, a small employer could be required to pay for insurance on a teenage employee while that teenager's father's employer could also be paying premiums for that teenager. To further illustrate this point, the following example is provided*:

Small businessman Jones owns and operates a nursery. Mr. Smith works for Mr. Jones and is covered by health insurance. During the spring and summer, business always picks up, so Mr. Jones hires four teenagers, including Mr. Smith's two sons. Two of the teenagers begin work May 15, and the Smith boys start June 1 and June 7. On June 15, small businessman Jones begins to pay insurance premiums on the first two teenagers hired (neither they nor Mr. Jones knows they are already covered under their parent's plans), but on June 20 one of them quits, to be followed by the second four days later. Two more teenagers (also unknowingly covered by their parent's plans) are hired June 25 and July 4th. The Smith boys leave the job to return to school on August 24 and September 1. The other teenagers leave September 14th, but one of the two drops out of school in a week and takes a full time job. Here is the result of summer employment for small businessman Jones:

--about 15 months of work
--nearly 30 months premiums paid
--no additional coverage secured for any employee
--considerable paperwork

Cost are not estimated here because it makes a considerable difference whether or not Mr. Jones's business is large enough to qualify as a group. This brings me to the problems cited by small business owners which originate from the product, or seller's, side of the market.

---

* This example assumes required coverage one month after employment through three months after job determination.

The two biggest reasons cited by small employers for non-coverage in this regard were that premiums are too high (overall this was the second most important reason for non-coverage) and that the firm could not qualify for a group policy. The one thing most often cited by small firms, especially the smallest, that would induce them to offer health insurance for all their full time employees was lower premium rates. It should be noted our data show that small businesses in the aggregate have had their premium costs doubled in the last eight years. In some industries, like transportation and the professional services, these costs have tripled in the last eight years. Part of the reason small employers face such large health insurance costs is that more than two-thirds of them paid the entire premium cost for their employees, and 87% of them paid more than half.
In addition, it is the smaller firms which pay a greater proportion of the premiums themselves.

The point for policy makers here is, however, that if they wish to increase the percentage of small business employees who are voluntary covered by health insurance plans, including health insurance, they should look to the health care industry and the insurance industry to ensure that the market is operating to provide the lowest prices. That is, to insure the market is operating efficiently and competitively. Not being an expert in either the health care industry or the insurance industry and having no policy guidance in this regard from my members, I will leave that judgment to others for the moment. I will note only that the cost of insurance, all types of insurance, has emerged as the number one problem of small businesses in this country.

The percentage of small employers that do not have any employee health insurance and who claim that they do not do so because they cannot qualify as a group has declined since 1978 from 25% to 12% in the aggregate. We attribute this drop to the fact that trade associations are increasingly acting as group sponsors. NFIB, for example, has recently became a group sponsor offering employee benefit packages to our members. While we expect this trend to continue and to improve the coverage problem, it is perhaps another area for policymakers to investigate. It may be feasible for the government to operate as a market maker in this area. While the inability to qualify as a group has declined, it still remains one of the major barriers to offering health insurance plans for small employers. NFIB is not advocating government involvement in this area, since we expect trade associations to increase their activities in offering group plans. It is, however, an aspect of the overall problem which may more easily lend itself to government involvement than would other aspects of the problem.

S. 2403, ACCESS TO HEALTH CARE ACT OF 1986.

To a considerable, and encouraging, degree S. 2403 is sensitive to the general concerns and recommendations that I have previously outlined. If only in that it apparently exempts those employers with fewer than 20 employees. But further than this, its approach does seem to be toward correcting market deficiencies and toward consumer choice. As you have noted elsewhere 5 or 6 years ago the proposals before Congress were considerably more intrusive and overbearing, in that they, almost universally, contemplated some form of federally administered national health insurance or nationally mandated all-payer insurance systems. As such, they were relatively easy for the small business community to react to -- they opposed them one and all. With the shift in the focus of the debate it is somewhat more difficult to be so unequivocable in our response. Having said that let me proceed, section by section, to the concerns for small businesses that I see in S. 2403.

Section II, Incentives for the Establishment of State Wide Insurance Pools:

I find nothing in our survey material or in our policy polls which would lead me to believe that our members either oppose such a program or would be adversely affected by it - at least, to the extend that any such program did not increase their existing employee health insurance premiums. I will note, however, that since the uncovered employees of small businesses would qualify for such a program and since small employers are increasingly able to qualify for group policies because of increased trade association sponsorship of them, that for this sector of the population the need for such a program is declining. I suspect, however, that your primary target group here is those people with existing medical conditions and not the uncovered employees of small firms.

I would add three comments on the language of this section:

1. Your definition of a large employer is not so generous as it at first appears. While it seems to preclude seasonal employees from coverage, it specifically includes part-time employees. Nearly 25% of all small business employees are part-time employees. And some industries, such as agriculture, retailing, professional services, and the hospitality industry, generally, rely particularly heavily upon part-time employees. In these industries an employer with significantly less than 20 full-time employees could find himself defined as a large employer. I would recommend re-working the definition so that it applied to those employers with 20 or more full time employees.

2. This is actually in the nature of a question. In the section defining "qualified pooling associations" where pool premium rates are discussed, will it not be the case that by capping pool premium rates to no more than 150% of average premium rates for individual standard risk in the state for comparable coverage you are ensuring that the pool will realize losses that

The participating members will have to make good? Since it is high risk individuals who are likely to select this insurance, is it not likely that it will be expensive to run such a pool?

It is also unclear to me how the payment of losses would be apportioned. The language says "equitably", but in this context that seems to me insufficiently clear.

3. It appears blatantly unfair to impose a 10% excise tax on "large employers" for the failure of state legislators, for whatever reasons they might have, to pass the necessary state implementing legislation to establish state wide insurance pools. The excise tax should come into effect only if a state creates such a pool and the "large employer" choses not to be a member.

Section III, Requiring State Programs for the Uninsured and Underinsured:

This section is beyond our expertise to comment on, other than to say, that if any state attempts to meet the requirements of this section by mandating increased payroll taxes or other labor based taxes, I would expect the small employers of that state to oppose it.

Section IV, Temporary Extension of Coverage for Laid Off Workers; Open Enrollment for Spouses of Unemployed Workers:

For all of the reasons cited in the previous section of this testimony we oppose the requirement for 4 months of employer paid health insurance beyond job termination (or reduction in hours). The realities of the labor market facing small employers are too stark not to expect a provision like this to have detrimental effects on employment, plan sponsorship, employer payment patterns (now, small firms, more often than not, pay 100% of premiums) or the survivability of many small firms. I will not re-argue the case made on pages 25 to 27, I will only add that the paperwork, alone, involved in notification and recordkeeping would be an overwhelming nightmare for the vast majority of small businesses.

If the committee insists on such a provision, I would make two recommendations:

> First, that a specific and simple mechanism be included to eliminate the possibility of double coverage by different employers.
>
> Second, that in the section of the Code giving as one of the qualifying events "termination of the covered employees employment (other than by reason of such employee's gross misconduct)" that "or quitting" be included. Such recommendations may help solve part of the problem, but they will increase, unfortunately, another - paperwork.

Other than its potential upward pressure on premium rates, I find no reason in our survey material or in our policy polling to oppose the open enrollment for spouses of unemployed workers. On the surface it appears like a good and humane idea.

Section V, Deduction Allowable for Certain Group Health Plan Contribution by Self Employed Individuals:

NFIB supports this provision and has supported its general thrust for a long time. We have done so as much based on the equity to the self employed individual as for its incentive effect on increased employee coverage. We consequently support the similar provision contained in the tax reform bill.

Section VI, Demonstration Projects on Improving Access to Health Insurance for Small Employers and Self Employed Individuals:

We, of course, heartily support this section, urge it be given a high priority, and volunteer to provide whatever assistance and resources we can to its successful completion.

APPENDIX A

MANDATE QUESTIONS ON HEALTH INSURANCE

DESCRIPTION	MANDATE #	DATE	FOR	AGAINST	UNDECIDED
Do you favor a mandatory national health insurance program? a) yes; b) yes, but catastrophic only; c) no; d) undecided?	400 (1)	12/76	a) 10% d) 3%	b) 34%	c)53%
If everyone were covered by a system of mandatory national health insurance, what benefits should be available? a) comprehensive; b) deductible; c) catastrophic only; d) undecided?	400 (2)	12/76	a) 6% d) 8%	b) 19%	c)67%
If a system of mandatory national health insurance were established, how should it be financed? a) general taxes; b) payroll deductions; c) premiums; d) undecided?	400 (3)	12/76	a) 24% d) 12%	b) 14%	c)50%
If a system of mandatory national health insurance were established, who should administer it? a) federal government; b) state government; c) private insurance companies; d) undecided?	400 (4)	12/76	a) 10% d) 12%	b) 10%	c)68%
Should employers be required to provide a minimum level of private health insurance for their employees? a) yes, and pay the entire premium; b) yes, and pay part of the premium; c) no; d) undecided?	400 (5)	12/76	a) 4% d) 5%	b) 19%	c)72%
A program of national health insurance to cover catastrophic illness only?	415 (3)	1/79	39%	55%	6%
The Medical Expense Protection Act?	426 (4)	4/80	14%	79%	7%

DESCRIPTION	MANDATE #	DATE	FOR	AGAINST	UNDECIDED
Taxing--as income to employees--employer-paid health-insurance premiums in excess of $175 per family, per month?	448 (2)	4/83	25%	72%	3%
Limiting the deductions for health insurance for employers?	451 (2)	11/83	26%	69%	5%
Taxing employees on fringe benefits?	459 (2)	4/85	24%	72%	2%
Allowing states to require certain types of coverage in employer-sponsored health plans?	462 (4)	12/85	9%	89%	2%

APPENDIX B

SURVEY SAMPLE

The preceding report was based on data gathered from a mail survey of small business owners conducted in September, 1985. The survey sample was randomly drawn from the membership file of the National Federation of Independent Business (NFIB). All regular members in the file were eligible for selection, the exception being a comparatively small percentage who had no full-time employees. Thus, the resulting sample consisted entirely of small employers. Each of the 7,750 small business owners in the sample received a questionnaire (a copy provided in Questionnaire, p. 46) and a follow-up two weeks later. There were 1,439 usable responses for a 19% response rate, 11 percentage points less than NFIB normally experiences in such surveys.

There is little a priori reason to fear a sample bias. Dunkelberg and Scott have demonstrated that the NFIB membership file reasonably reflects the universe as the universe can best be estimated. Moreover, the sample was not contaminated by association activities involving extensive sale or promotion of employee benefit packages. And while response rates of 30%, let alone 19%, never can provide a survey analyst comfort, previous experience in comparing NFIB-collected responses to equivalent data collected by other organizations shows remarkable consistency, particularly within size class. The differences that do exist usually involve "levels" for the entire population resulting from the somewhat larger businesses within the NFIB file.

Tables A and B provide comparisons of the estimated universe, the survey sample, and the survey respondents. (The estimated universe measures were drawn from the Small Business Administration's (SBA) Small Business Data Base as published in the annual The State of Small Business Report.) Note on Table A that the industry-by-industry differences in these data sets are minimal. Survey respondents are somewhat overrepresented among manufacturers and underrepresented among services. In the other major industries, however, differences usually involve only a percentage point or two.

When employee size is substituted for industry in the three set comparison (Table B), the result is not as satisfactory. The profile of survey respondents and the survey sample are virtually identical, with the exception of 1-4 employee class size and "no answer." Distributing the no answers proportionally among all size classes creates a survey respondent profile still somewhat underrepresented in the 1-4 employee class and a percentage point or two overrepresented in the others. That distribution in and of itself should be sufficient to cover all concerns over the response rate. However, the responses of "no answers" and the responses of other size classes to other comparable questions produce an uncommon similarity between the "no answers" and the 1-4 employee size class. Given that similarity and previous experience which indicates the smallest are most likely not to respond to size questions, responses proportionally allocating "no answers" probably do not assign enough to the smallest size class. As a result, the profile of survey respondents and the survey sample is probably even better than the considerable similarity previously shown.

Table A

COMPARISON OF ESTIMATED UNIVERSE, SURVEY SAMPLE, AND SURVEY RESPONSES BY INDUSTRY
(in percent)

INDUSTRY	ESTIMATED UNIVERSE	SURVEY SAMPLE	SURVEY RESPONDENTS
Construction	14	11	12
Manufacturing (includes Mining)	9	13	13
Transportation	4	3	4
Wholesale	10	7	10
Retail	29	27	27
Agriculture	4	5	5
Financial Services	8	7	9
Services	24	24	19
No Answer	--	2	1
Total	100%	100%	100%

While the estimated universe inflates the 1-4 employee size class a percentage point or two by inclusion of some non-employers, there remains a difference between the estimated universe and the sample. Sample small business owners (as well as respondents) have somewhat larger businesses on balance. The estimated universe contains approximately 10 percentage points more firms in the 1-4 employee size class than did the sample on the response. Those 10 percentage points were distributed over other size classes. Thus, population "levels" are unduly influenced, though not greatly, by owners of firms larger than 1-4 employees.

Table B

COMPARISON OF ESTIMATED UNIVERSE, SURVEY SAMPLE, AND SURVEY RESPONSES BY EMPLOYEE SIZE

(in percent)

EMPLOYEE SIZE	ESTIMATED UNIVERSE	SURVEY SAMPLE	SURVEY RESPONDENTS
1-4	57	48	37
5-9	21	21	21
10-19	11	15	15
20-49	7	11	10
50-99	2	3	4
100 or more	2	2	3
No answer	--	1	11
Total	100%	100%	100%

ERIC

The
ERISA
Industry
Committee

SUMMARY

Testimony of
The ERISA Industry Committee

for the
Committee on Labor and Human Resources
United States Senate

Hearing on S. 2402
Access to Health Care Act

Wednesday, July 16, 1986

The ERISA Industry Committee appreciates the opportunity to present its views on S. 2402, Access to Health Care Act of 1986.

The ERISA Industry Committee (ERIC) represents the concerns of major U.S. employers on public policy matters affecting private sector retirement and employee benefit plans. ERIC's over 100 members provide important retirement, health, and other life security protections for over an estimated 10 million active and retired workers in every state of the nation.

ERIC companies have long played a leadership role in providing affordable and cost effective health coverage to their employees and their dependents.

We are deeply concerned about and strongly object to Sections 2, 3 and 4 of S. 2402. These sections would:

(1) decrease rather than increase employer-sponsored health coverage;

(2) further inflate the cost of health care by providing a disincentive for fiscal restraint under the new health coverage provided by the bill;

(3) unfairly impose the costs of subsidized health insurance pools on only those private sector employers already shouldering substantial health care burdens; and

(4) impose on these same employers a disproportionate share of health care responsibilities.

We do not believe that these are results that the bill sponsors or the Committee would find acceptable, and we offer the following recommendations:

1. Precipitous action on a bill vaguely drafted and containing major disincentives to the continued general coverage of workers and dependents would be a mistake. The Committee should hold additional hearings and explore other approaches to correcting the problems addressed by the bill instead of deciding on the course of action mandated in S. 2402.

(over)

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2. In no instance should the cost of providing coverage for non-employees be imposed solely on private sector employers that are already providing coverage for their employees while other employers and government entities reap the benefits without assuming their fair share of the costs.

3. Similarly, there is no reason to exempt small employers from this societal cost. Many small employers, including professional corporations, may be in a stronger financial condition than the larger employers targeted by the bill.

4. If fiscal responsibility is to be maintained, those paying for the care must have a direct voice in determining the extent of benefits and coverage provided.

5. Non-hospital care should be used to provide affordable health care.

6. Minimum service requirements should be imposed before employees are eligible for continued coverage in order to avoid creating an incentive for employers to delay coverage of newly hired workers and to prevent some workers from taking unfair advantage of the system.

7. All revenue gained from any programs adopted should be specifically dedicated to the health care of those the bill seeks to protect.

8. Employees whose employment is terminated voluntarily or for cause should be excluded from continued coverage (cf. standards used for unemployment compensation).

9. If the federal government mandates additional coverage, the scope of ERISA preemption should be expanded to pre-empt existing state laws that mandate coverage or benefits.

10. The tax imposed on employers for actions taken or not taken by state legislatures should be removed from the bill.

11. Finally, the scope of benefits required to be provided under risk pool and post employment programs should be narrowed.

ERIC/cab:7/15/86

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We do not believe that these are results that the bill sponsors or the Committee would find acceptable, and we offer the following comments in an effort to point out the problems that would be created by S. 2402.

STATEWIDE INSURANCE POOLS

Section 2 of S. 2402 requires all states to establish state pools to finance health coverage for all residents of the state who are not eligible for Medicare. The coverage provided must limit out of pocket expenses to $1,500, include a lifetime benefit limit of not less than $500,000, cover pre-existing conditions after six months, and charge a premium of no more than 150 percent of the average premium for individual standard risks in the state.

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If the premiums charged to individuals fail to finance all of the required benefits, the employers that already provide coverage for their own employees would, in addition, have to pay for the additional costs of the pool. Any employer that provided coverage for its employees but did not participate in the pool (even where the state failed to create such a pool) would be required to pay a tax equal to ten percent of the health expenses that it incurred on behalf of its employees.

By contrast, a competitor that provided no health coverage for its employees would not have to participate in the pool and would not be subject to the ten percent penalty tax.

No government entity would participate in the costs of the subsidized pool or be subject to the tax.

The money raised by the penalty tax would be part of the general treasury; it would not be reserved to provide health care benefits.

The provisions of Section 2 provide a combination of incentives for increased cost and disincentives for expansion of employer-provided health coverage that ERIC finds disturbing, unfair and counterproductive.

Under the terms of the bill an employer would pay a penalty tax of 10% of the health benefits provided to its employees if a state's legislature fails to pass or chooses not to pass risk pool legislation meeting the requirements of the bill. There is no justification for taxing an employer on the basis of what a state legislature chooses to do or not to do.

Moreover, state legislatures that do establish pools will be under political pressure to keep the premiums charged to individuals low. Our preliminary analysis, based on costs of a major company plan with general health benefits similar to the requirements stipulated in the bill indicate premiums for coverage required in the bill would amount to approximately $60 per month for individuals and $160 per month for families. Given the low average wage of individuals who do not have employer-provided health coverage, premiums of this magnitude would be too high for widespread use. As a result, only those individuals who are most likely to file claims will choose to join the pool. Our calculations were based on a standard risk population. However, S. 2402 requires coverage of pre-existing conditions after six months. Both the costs of the participation in the pool and the coverage pre-existing conditions will cause adverse selection. This adverse selection will increase costs even further. The premium costs almost certainly will have to be subsidized heavily by the risk pool.

Moreover, there appears to be no limit on the benefits that a state could require to be covered under a state risk pool. 600 state mandated benefit laws are now on the books. A legislature will be under political pressure to extend those requirements to a state risk pool. Benefits mandated by current state laws include coverage for podiatry, chiropractors, drug abuse, alcoholism, social workers, acupuncture, sterilization, liver transplants, in vitro fertilization, pastoral counseling, chinese medicine, "all healing arts practitioners", and a host of other benefits. However meritorious, these benefits are not "basic health care."

Although little data currently exists on the impact of existing risk pools, the movement of large employers toward self-insured plans, which currently are not subject to state pooling arrangements, the reduction in the coverage provided by smaller employers, and the insistence by sponsors of insured plans that other entities should shoulder some of the cost of these pools all indicate that risk pool subsidies are proving expensive. Available data indicate that the cost of the pool subsidies is increasing faster than the general increase in health care costs.

The bill provides no mechanism for fiscal restraint on health care costs or on the subsidy of those costs. State entities will set the coverage and subsidized premium levels. Employers already providing coverage to their employees will pick up the cost. Even the normal restraints that exist when a government body must levy taxes in order to pay for services do not exist here. This bill extends the "deep pockets" theory of liability to health insurance.

The exemption for small employers would exempt from the costs of the risk pool subsidy highly profitable businesses, including professional corporations, while imposing added cost burdens on larger employers that may or may not be profitable at any given time.

The exemption of government entities from the costs of the risk pool subsidy would dramatically increase costs for other employers in states with high concentrations of federal or other government installations, reducing the ability of such states to attract profitable private sector employers.

Since it is based on health expenses paid during the year, the ten percent penalty tax would reward employers that provide little or no health benefits and would penalize employers that provide more adequate benefits.

For all of these reasons, ERIC opposes the risk pool provisions of S. 2402. The net impact of this portion of the bill as written will be to provide additional health coverage for a minimal number of individuals at a high cost while reducing general coverage under employer-sponsored health plans, that now protect over 150 million Americans.

STATE PLANS FOR UNCOMPENSATED CARE

Section 3 of S. 2402 requires that each state establish a comprehensive program to pay for uncompensated care throughout the state if hospitals in the state are to continue their Medicare eligibility.

While pursuing the bill's goal of ensuring that all individuals have access to health care, these provisions would also have adverse effects:

(1) By providing compensation only for hospital care, the uncompensated care provision would subvert the current effort to provide cost effective care by minimizing to providing alternatives to hospital care.

(2) Since medical needs would be handled through a state system, the provisions provide further incentives for some employers not to assume the costs of providing care for their workers.

ERIC recognizes that uncompensated care is an important and increasing national problem. Solutions in this area, however, should both recognize the variety of means by which health care can be provided both nside and outside hospitals and should not be so broad in scope as to encourage employers to avoid providing coverage for their own employees.

PROVISION OF EMPLOYER PAID INSURANCE FOR FORMER EMPLOYEES AND OPEN ENROLLMENT FOR SPOUSES

Section 4 of the bill requires private sector employers that provide health coverage for their employees to extend that coverage under the same costs and conditions for a period of time for any employee who leaves.

Despite the use of the term "laid off employees" in the section heading, this provision would include all former employees -- employees who voluntarily quit, who retire, or whose employment is terminated for cause, as well as employees who are laid off in a workforce reduction. Only employees terminated for "gross misconduct" (an extremely limited term) would be exclud

No minimum service is required for eligibility for the extended coverage. The bill requires employers to pay for continued health coverage for four months or for the number of months the worker was provided coverage under the company's group plan, whichever is less. As a result, employers -- particularly employers with high turnover in the first months of employment -- would be strongly discouraged from providing any health coverage at all to employees until they have been with the company for some time. Thus, coverage gained at the back door could be more than lost at the front door.

The range of benefits for which coverage must be maintained appears to be extremely broad. Under such broad definitions, a former employee may have strong incentives to seek elective treatments under dental or vision care programs or other similar benefits "before time runs out." Such adverse selection would increase costs of these programs and reduce the ability of employers to offer them on an ongoing basis to active employees while not providing any significant additional protection against medical emergencies for former employees.

RECOMMENDATIONS

1. Precipitous action on a bill vaguely drafted and containing major disincentives to the continued general coverage of workers and dependents would be a mistake. The Committee should hold additional hearings and explore other approaches to correcting the problems addressed by the bill instead of deciding on the course of action mandated in S. 2402.

2. In no instance should the cost of providing coverage for non-employees be imposed solely on private sector employers that are already providing coverage for their employees while other employers and government entities reap the benefits without assuming their fair share of the costs.

3. Similarly, there is no reason to exempt small employers from this societal cost. Many small employers, including professional corporations, may be in a stronger financial condition than the larger employers targeted by the bill.

4. If fiscal responsibility is to be maintained, those paying for the care must have a direct voice in determining the extent of benefits and coverage provided.

5. Non-hospital care should be used to provide affordable health care.

6. Minimum service requirements should be imposed before employees are eligible for continued coverage in order to avoid creating an incentive for employers to delay coverage of newly hired workers and to prevent some workers from taking unfair advantage of the system.

7. All revenue gained from any programs adopted should be specifically dedicated to the health care of those the bill seeks to protect.

8. Employees whose employment is terminated voluntarily or for cause should be excluded from continued coverage (cf. standards used for unemployment compensation).

9. If the federal government mandates additional coverage, the scope of ERISA preemption should be expanded to pre-empt existing state laws that mandate coverage or benefits.

10. The tax imposed on employers for actions taken or not taken by state legislatures should be removed from the bill.

11. Finally, the scope of benefits required to be provided under risk pool and post employment programs should be narrowed.

ERIC/cab:7/15/86

STATEMENT OF
SELF INSURANCE INSTITUTE OF AMERICA, INC.
ON
"THE ACCESS TO HEALTH CARE ACT OF 1986"
(S. 2402)

This statement is submitted on behalf of the Self Insurance Institute of America, Inc. ("SIIA"), a national association of over 600 members including employers, third-party administrators, reinsurance companies and other interested parties dedicated to the improvement of the self-insurance industry.

SIIA appreciates the opportunity to express its views on S. 2402, "The Access to Health Care Act of 1986", which would, among other things, require that employer sponsored group health plans provide health insurance benefits for four months for employees who are laid off as well as their dependents.

In brief, SIIA supports the present system of voluntary, employer sponsored health plans which provide benefits to millions of employees. These plans are tailored to meet the varying needs of employers and employees in accordance with the unique requirements of the employer-employee relationship. SIIA opposes federal controls which would mandate special coverages because they would increase already spiralling private sector health costs and limit flexibility in plan design. Such action will impact adversely on the private voluntary system and will create less rather than greater coverage. Indeed such legislation would be particularly burdensome for smaller employers who may have to lower wages or eliminate group coverage altogether.

Federal Mandates Will Reduce Coverage

For over 50 years employers have taken the initiative on a voluntary basis to provide employer sponsored, and in many cases, employer paid health benefits to their employees. Recently, the President signed into law legislation which mandated that employer sponsored group health plans, whether insured or self-insured, must allow previously covered spouses and dependents of former employees to elect to continue health coverage. On the heels of this new law, Congress is now considering yet another Federal law, S. 2402, which would intrude once again into the private health care system by mandating that additional benefits be provided under private plans.

This law requires, among other things, four months of employer paid health benefits for laid off workers. This latest mandate will make it even less attractive for employers, particularly small employers, to continue to provide employer sponsored health benefit programs. In short, as the Federal government continues to mandate the inclusion of health care benefits, we are concerned there will be a deterioration of this voluntary system and employers will elect to discontinue providing employer sponsored (paid) health care coverage. Thus, we submit that S. 2402 is not in the best interest of employees, dependents of employees, employers, providers of health care, and the general population.

Private Voluntary Health Care System Works Effectively

The vast majority of our population is in fact covered by some form of health care, whether provided through private group funding arrangements or through the Government. Private sector plans are designed to meet the specific needs and financial resources of employers and employees. Employers now spend an estimated $100 billion each year on health care for their employees. As employer sponsored health care plans have multiplied, basic medical coverages have expanded, and new programs have been added to cover medical expenses beyond the traditional exposures. For example, dental protection as well as other forms of health care protection such as vision care, long term and short term disability are now provided under many employer sponsored health care programs. Moreover, ERISA gave employers an opportunity to provide uniform benefit plans without state government interference when they elect to self fund the benefits rather than use the services of a commercial insurer. ERISA's broad Federal preemption provisions, which preclude state regulation of welfare benefits plans, implicitly reflects Congress' rejection of minimum standards for such plans, including coverage. This private system is working well and should not be burdened with costly new requirements which would inhibit its continued growth.

S. 2402 will erode the concept of voluntary employer sponsored programs. Although the concern of government to expand the availability of health insurance to those who are not presently covered is understandable, we do not believe the answer to this problem lies in mandating the inclusion of such coverage in private plans. In effect, S. 2402 seeks to establish a form of national health care, by shifting costs to employers rather than to the public.

Reasons For Rejecting New Federal Mandate

S. 2402 should be rejected for the following reasons:

1. It places new burdens on the free enterprise system which will result in increased costs to employers. The cost to provide and fund benefits for the uninsured will be passed on to the employer in the form of: (a) increased administrative cost; (b) poor plan experience causing increased cost to all participants; and (c) adverse selection against the plans.

2. It would favor interest groups especially those who represent the provider sector of the health care industry. For the past several years, health care costs have continued to rise and treatment of conditions in many situations may have gone far beyond what is required. Providers have long capitalized on funding their services through group health care arrangements. The medicare program is living proof of what a blank check can do to any provider. This will surely exacerbate the problem of rising costs.

3. It mandates that employers must continue their group health plan for employees who terminate regardless of the reason for termination and their dependents. Employer sponsored plans are designed to cover the active work force, not those who elect

to leave the company or are laid off. In fact most group plans already contain provisions for such occurrences and in many cases provide the right to convert to individual plans. However, such rights are not granted regardless of the reasons for termination. To mandate that employers must continue coverage for employees who terminate and, at the cost of the employer, will undermine the employer-employee relationship and will create a further incentive for many employers to drop their employer sponsored benefit plans. Should this occur, an even greater "uninsured" problem will be created.

4. The provision for a special open enrollment would have a devastating effect on group plans. S. 2402 provides the opportunity for employed spouses of laid off workers to "select" against the group plan which will result in higher benefits, resulting in adverse experience requiring substantial rate adjustment to the employer sponsored plan. This is unfair cost shifting.

5. S. 2402 also requires all states to establish "pools" to cover all people who do not have health insurance, even if they elected not to purchase coverage on their own. Yet, many states ~~already~~ have in place some form of social aid and state residents as well as business are already helping to fund these state programs. S. 2402 will only serve to complicate matters and make "health care abuse" an even more attractive activity than it already is.

On the positive side, S. 2402 would create a new incentive for small business to provide benefits to all employees as well as the owners of sole proprietorships, partnerships and sub-chapter corporations. Under this provision, employers will be able to deduct their personal premium provided they extend the offer to include their employees under the plan. This provision we can support.

In conclusion, S. 2402 does not solve the problem of providing coverage to uninsureds. It would only place further burdens on the private system and will encourage greater abuses in the health care provider sector. Inevitably reduction in the protection afforded by private health plans will place new burdens on already over utilized government programs. We urge you to reject S. 2402 and to continue present broad tax incentives for American business to continue to provide effective employer sponsored health care plans without mandating the content and scope of these plans.

Supplemental Sheet

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August 5, 1986

Honorable Orrin Hatch, Chairman
Labor and Human Resources Committee
527 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Hatch:

We are submitting this letter as written testimony to be included in the record of the hearing which was held on July 16, 1986 concerning infant mortality and access to health care. The infant mortality rate has fallen sharply since the late 1960s. Much of the recent decline reflects a decrease in neonatal mortality and is due to the increased survival of low birth weight infants and newborns with other problems. While this decline is gratifying and should not be minimized, several factors point to the need for additional efforts:

° continued disparities in the mortality rates among blacks and whites;

° a recent slowing in the rate of decline in infant mortality raising concerns about achieving a "plateau";

° a possible recent increase in post-neonatal mortality.

There is little doubt that an early start of prenatal care is associated with better pregnancy outcome. The evidence suggests that prenatal care has reduced some problems leading to low birth weight. Where the birth of a high-risk infant cannot be prevented, systematic, uniform risk assessment throughout the course of pregnancy leads to recognition of risks at a point which permits referral/transport to a specialized center.

Deaths in the first month of life primarily reflect factors associated with health of the mother before and during pregnancy and the special problems of the newborn. Neonatal mortality rates provide an indicator of the factors affecting pregnancy, delivery and the neonate, and the adequacy of services in the prenatal, intrapartum and neonatal period.

Post-neonatal rates mainly reflect deaths due to infection (respiratory illness, gastroenteritis), Sudden Infant Death Syndrome (SIDS) and injury. Pediatric age patients who are victims of accidental injuries have rapidly progressive emergencies that differ significantly in pathophysiology from emergencies in adults. The development of an available emergency medical system having the special knowledge, personnel and equipment to meet the needs of the pediatric patient and injury prevention research are important components of a program to combat infant mortality. Since the prevalence and severity of these conditions are related to socio-economic status and access to care, changes in post-neonatal mortality rates are sensitive indicators of the health problems of poor families.

Poverty is a proxy for several manifestations of need and children are disproportionately represented in the population who are poor. It is clear that third party payment of care from whatever source increases access to care, and thus those with insurance (public or private) get more care. Access to appropriate personal medical care is an important component of a community's commitment to the health of children during the period of fetal growth and development and throughout the periods of childhood and adolescence.

The rate of infant death is significantly higher among some vulnerable groups than in the general population. Data have identified Blacks, Native Americans, Spanish surname populations, and other strata within the population as examples of such groups. In groups with the higher infant mortality rates, one finds higher aggregations of low income, limited access to health care and limited understanding of the benefits of early and regular health care. Manifestations of higher frequencies of compromised nutritional status, existing medical conditions, medical complications during pregnancy and shortened intervals between pregnancies, all of which are associated with poor pregnancy outcomes, are more common in these vulnerable groups.

These factors, in association with low birth weight, post-neonatal infections and injuries, produce higher neonatal and post-neonatal mortality rates. Lowering the infant mortality rate for these groups requires more than episodic efforts or efforts focused solely on care once pregnancy begins or after the compromised infant is born.

The Academy urges research support in basic areas such as the mechanisms explaining congenital malformations, low birth weight, and the limiting effects of poverty on child health. Similarly, aggressive attention should be given to support research in applied problems of financing health care, the structure of health care and the outcomes of adequate and inadequate health care. Changes in infant mortality rates are a signal of broad changes affecting child health. We applaud your efforts to effect positive changes which will benefit children from all segments of our population.

Sincerely,

Martin H Smith MD

Martin H. Smith, M.D.
President

MHS/lck

HEALTH
INSURANCE
ASSOCIATION
OF AMERICA
1025 Connecticut Avenue, N.W., Washington, D.C. 20036-3998, (202) 223-7780

July 17, 1986

The Honorable Orrin G. Hatch
Chairman
Senate Labor and Human Resources Committee
United States Senate
Washington, D. C. 20510

Dear Mr. Chairman:

The Health Insurance Association of America fully supports legislation to encourage states to establish voluntary risk pools for uninsurables. We particularly commend Senators Kennedy and Riegle for sponsorship of Federal legislation on this issue in S. 2402. The commercial health insurance industry has actively supported such a measure since the late 1960's as a key building block in efforts to bridge existing gaps in coverage. Now is the time to make this concept a reality and we urge its inclusion in current pending legislation.

Joining the HIAA in its support of state risk pools for uninsurables are more than 3 dozen national organizations representing millions of this country's most vulnerable citizens--the sick, handicapped, and elderly. Together we recognize that in many cases those unable to obtain health coverage are working people who are willing and able to pay for insurance but are unable to obtain it because of poor health.

The fact that the great majority of Americans do have some type of insurance coverage provides little comfort to those who must go without.

State high risk pools work by spreading the excess financial risk of covering otherwise uninsurable individuals among all health insurance plans in the state, including self-insured businesses. The risk pools set a ceiling in the premium charged which, when combined with the health status of the persons in the pool, can generally be expected to produce pool losses. The key to effective operation of the pools is to assure that these losses are spread proportionately among all the competitors in the health insurance market place. They do not represent a great financial burden on any one insurer if financed by adequate premiums and if the losses are spread equitably over the entire insured population.

We stress that the state risk pool proposal would not require a single dollar in Federal revenue. It should in fact save scarce Medicaid dollars, since, by making insurance available it will prevent many Americans from being forced into poverty and onto Medicaid by catastrophic medical bills. Thus, it will also help ameliorate hospitals' growing bad debt and uncompensated care problems, thus making more funds available for the truly needy.

Mr. Chairman, as you know, we are currently implementing the Federal continuation of benefits provisions of the Comprehensive Omnibus Budget Reconciliation Act of 1986. Pursuant to our discussion I have also enclosed a series of suggested amendments designed to ease the implementation and administration of those provisions without undercutting their basic intent, as well as more complete statements of the HIAA and the coalition for Health Insurance Availability on state risk pools.

Sincerely yours,

Linda Jenckes

Linda Jenckes
Vice President, Federal Affairs

Enclosures

cc: Members of the Senate Labor and Human Resources Committee

STATEMENT

of the

HEALTH INSURANCE ASSOCIATION OF AMERICA

on

STATE RISK POOLS TO GUARANTEE THE AVAILABILITY OF HEALTH INSURANCE TO ALL AMERICANS

S. 2402

Before the

SENATE LABOR AND HUMAN RESOURCES COMMITTEE

July 16, 1986

The Health Insurance Association of America appreciates this opportunity to comment on proposals to make health insurance available for persons considered uninsurable due to poor health. The HIAA is a national trade association comprised of 335 companies which underwrite or administer approximately 85% of the private commercial health coverage in this country.

We particularly commend Senators Kennedy, Heinz, Durenberger and Riegle for sponsorship of Federal legislation on this issue, S. 2402, S. 2403 and S. 1372. With your leadership, we can make private health coverage available to those Americans who might otherwise be denied insurance because of poor health.

The HIAA fully supports legislation to encourage states to establish voluntary risk pools for uninsurables. The commercial health insurance industry has actively supported such a measure since the late 1960's as a key building block in efforts to bridge existing gaps in coverage. Now is the time to make this concept a reality.

Joining the HIAA in its support of state risk pools for uninsurables are nearly 50 national organizations representing millions of this country's most vulnerable citizens--the sick, handicapped, and elderly. Together we recognize that in many cases those unable to obtain health coverage are working people

people who are willing and able to pay for insurance but are unable to obtain it because of poor health. In other cases, they are older people who, upon leaving their employment, find they cannot purchase individual coverage. At the time they need health insurance most, they are left without it. The inability to obtain adequate insurance has serious consequences not only for these individuals but for their families as well.

Before continuing, we wish to point out that the concern here is focused on a relatively small fraction of the population, and that the vast majority of working Americans are already covered by health insurance. The HIAA estimates that at the end of 1983, approximately 176 million persons under age 65, including spouses and children, were covered by one or more forms of private health protection. Eighty-five percent are covered by employee group insurance, usually without individual medical underwriting. About fifteen percent are covered by individual health insurance policies. These individual policies will generally continue coverage for persons with health problems once purchased, but in accordance with general insurance principles must have been purchased while the buyer was in good health. Thus, some individuals, such as those not eligible for group or group conversion coverage and those never having been in good health, may fall between the cracks.

The fact that the great majority of Americans do have some type of insurance coverage, however, provides little comfort to those who must go without. The HIAA feels that universal private health coverage for all employees and their dependents is an important national social goal; in this vein, we see no reason not to cover everyone who's willing to pay. Thus state high risk pools are designed to be the insurer of last resort for individuals who want health insurance protection and currently can't get it in today's health insurance market place.

State high risk pools work by spreading the excess financial risk of covering otherwise uninsurable individuals among all health insurance plans in the state, including self-insured businesses. The risk pools set a ceiling on the premium charged which, when combined with the health status of the persons in the pool, can generally be expected to produce pool losses. The key to effective operation of the pools is to assure that these losses are spread proportionately among all the competitors in the health insurance market place. They do not represent a great financial burden on any one insurer if financed by adequate premiums and if the losses are spread equitably over the entire insured population.

For example, in 1985 the losses of the Minnesota state pool were approximately $5 million. If spread over all insured lives under age 65 in Minnesota, including all protected employees and their dependents, losses would be approximately $1.40 per person per year. In Connecticut, 1985 losses were approximately $1.5 million or $.50 per person. Eleven states currently have some form of health insurance pool for uninsurables: Connecticut, Florida, Indiana, Iowa, Minnesota, Montana, Nebraska, North Dakota, Rhode Island, Tennessee, and Wisconsin. In 1975, the HIAA supported the creation of the first state risk pool in Connecticut. Because of the this pool, there are now no uninsurables in Connecticut. Under the Connecticut law, the losses of the pool were to be shared among all the competitors in the health insurance market place -- the commercial insurers, Blue Cross/Blue Shield, HMO's, and self-insured employers -- on a pro-rata basis. Thus, the high-risk individuals received coverage but the competitive market place was not upset.

Subsequent court interpretation of the 1974 Employees Retirement Income Security Act (ERISA), however, which precludes the states from regulating employee benefit plans, means self-insured employers need not share in any pool losses. As more and more large employers self-insure, the burden of pool losses falls harder and harder on an ever decreasing base, principally small employers and individual purchasers of health insurance policies, who are already paying higher costs for their health protection.

The state risk pool provisions of S. 2402, as well as S. 2403 and S. 1372, provide a powerful incentive for all states to establish risk pools by levying a 10 percent penalty on employers, including self-insured employers, that do not participate in qualified pools. Because employers will find it much less costly to participate in the pool, there should be no revenues from the penalty provision. Instead, the actual financing of the pools will come from the private sector. The design and operation of the insurance pools will be at the discretion of each state, and they will be regulated by the state like any other insurance product. The HIAA endorses all of these concepts.

We should stress that the state risk pool proposal would not require a single dollar in Federal revenue. When you consider this in light of the fact that industry and consumers are joined in support of a measure to solve the health care needs of Americans currently left out of our private health insurance system, we see little reason why the measure should not be swiftly approved by Congress.

The HIAA believes that this legislation is a creative solution to a growing problem. While it does not resolve the health care problems of the poor, it will prevent many Americans from being forced into poverty and onto Medicaid by catastrophic medical bills.

It will help ameliorate hospitals' growing bad debt and uncompensated care problems, thus making more funds available for the truly needy.

We would also like to comment very briefly on the other major sections of the Access to Health Care Act. Our industry certainly endorses the concept of providing tax incentives to individuals and small business people to purchase health insurance for themselves and their employees. However, the concept of requiring employers to continue payment for health insurance coverage for terminated employees for a period of 4 months requires thoughtful consideration. Health insurance in America is provided primarily through employment based coverage. Consequently, any requirement to continue coverage for a temporary period certainly has merit. We are, however, concerned about the possible counter-cyclical impact of the requirement to make employers responsible for payment. Frequently, this requirement would come into effect at a time when an employer, and particularly a smaller employer, may be least able to afford the extra burden of covering terminated employees. It is quite possible, that with some additional changes in the tax law, pre-funding of these kinds of benefits may be feasible. However, we would like to reserve judgment and suggest continued study of this aspect of the proposal to carefully consider all of the economic implications.

We are currently implementing the Federal Continuation of Benefits provisions of the Comprehensive Omnibus Budget Reconciliation Act of 1986. The superimposition of Federal requirements on existing state legislation is causing an immense amount of confusion, not only for our insured employers, but for the Federal drafters of regulations as well. It will be important in this piece of legislation and other Federal legislation that impose insurance requirements on employers, to consider carefully the interaction of Federal laws with state laws and to override state laws, if necessary. We have discussed this issue with you in the past, and are prepared to renew this discussion with you and your staff. An attachment to this statement contains suggested amendments to COBRA designed to ease its implementation and administration without undercutting its basic intent.

Finally, we are firmly convinced that as the American health care system moves to a more competitive approach, the issue of uncompensated care must be dealt with decisively. States pools that redistribute hospital revenues to needy institutions have been established in 5 states and seem to be working. However, at least 15 responsible national trade associations and consulting firms are examining broad-based solutions to the problems of funding uncompensated care.

We believe there is universal agreement that the solution must be a broad-based partnership between government and the private sector, and we are certain that given just a little more time and study, the right answers will emerge. We would prefer more definitive instructions to the states, rather than the somewhat open-ended approach described in this legislation.

In conclusion, we believe the risk-pool provision contained in the Access to Health Care Act will ensure the availability of health insurance for all Americans, regardless of the condition of their health, with an absolute minimum of Federal regulation, and at no cost to the Federal treasury. The Health Insurance Association of America urges enactment in this Congress of this important health care measure.

A copy of the statement of the Coalition for Health Insurance Availability is also attached.

July 15, 1986

COBRA AMENDMENTS

AMENDMENT 1 Insert as Section 609.--State Laws:

Notwithstanding any other provision of the Employee Retirement Income Security Act of 1974 (29 USC 1001, et seq), Part 6 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974 ("this part") supersedes any provision of state law which requires continuation of coverage under any group health insurance policy or group health benefit plan if such policy or plan is provided by an employer subject to this part.

With respect to the Public Health Service Law provisions of COBRA, we recommend the following parallel amendment as Section 2209. STATE LAWS.

Notwithstanding any other provision of law, Title XXII of the Public Health Service Act ("this title") supersedes any provision of state law which requires continuation of coverage under any group health insurance policy or group health benefit plan if such policy or plan is provided by an employer subject to this title.

Rationale: Some 34 states have existing statutes requiring group health insurance policies issued to employers to provide certain periods of continuation of coverage. None of these 34 state statutes apply to self-insured employee benefit plans due to the ERISA preemption. Few, if any, of these state laws are uniform in their requirements as to covered beneficiaries, the conditions under which continuation is available, the notice requirement, election periods, the mode of premium payment, conditions which terminate continuation, nor with reference to numerous other specific details. Further, none of these 34 state statutory requirements are the same as those imposed under COBRA. (See comparative charts attached hereto.)

These conflicting periods of continuation cannot be construed to run consecutively - first under state then under Federal law, since the Federal continuation right becomes effective with the occurrence of the qualifying event as contrasted with state laws under which the right generally becomes effective on the date coverage would otherwise have terminated due to a similar "qualifying event." Similarly, these periods cannot be construed to run consecutively - first Federal and then state, since such interpretation would abrogate the intent of those state laws. The proposed amendment will make the Act clear regarding such interpretations otherwise resulting in some kind of consecutive operation of these conflicting state and Federal requirements.

Employers provide employee benefits plans on an insured, partial insured, and on a self-insured basis. To the extent to which employee benefit plans are provided through insurance, an employer within the scope of COBRA must comply with COBRA as well as the various and very different state continuation requirements. These dual and inconsistent requirements will, to the extent both can be administered, add unnecessary but substantial administrative costs, perpetuate the substantive differences in the treatment of insured and self-insured plans and the beneficiaries thereunder, create undue complexities for plan operation by employers and plan administrators, be terribly confusing to individual beneficiaries and create a system lacking in basic fairness as to beneficiaries as a class. Therefore, it is essential to remove these inconsistencies and dual requirements as they apply to COBRA employers. The amendments do so not by preempting all such state laws, but rather by preempting only those provisions applicable to employers subject to COBRA.

This amendment would, as to employers subject to COBRA, preempt those provisions of state continuation laws to the extent to which such state laws would otherwise apply to employers subject to COBRA. This amendment will establish uniformity and complete clarification of the interaction between federal and state statutory requirements.

AMENDMENT 2 (Attached copy page 2)

The existing provision appears to exempt from the Act any multiple employer plan in which all employer members employ fewer than 20 employees. It leaves considerable uncertainty as to multiple employer plans in which some employ fewer than 20 and some others employer more than 20. The requirements of COBRA should be consistent with other Federal laws dealing with obligations of employers.

The proposed amendment conforms COBRA to the Age Discrimination in Employment Act and is intended to be interpreted by the Treasury Department consistent with existing interpretive regulations by HCFA with reference to the ADEA requirements.

AMENDMENT 3 (Attached copy page 2)

Clearly, the purpose of COBRA is to extend availability of group health plan coverage to those who would otherwise be left without coverage when employee health benefit plan coverages would terminate. COBRA is not intended for the prupose of creating duplicating coverages (See termination of continuation when other coverages are acquired.)

The amendment makes this intent clear and provides that continuation of coverage under the plan is not required in situations where the beneficiary already has other coverage at the time the qualifying event occurs.

AMENDMENT 4 (Attached copy page 2)

Rationale: The existing provision, while intended to define when continuation of coverage commences and ends, fails to do so in a clear and unambiguous way. The present law may permit interpretations under which an individual might be able to delay the beginning of a period of continuation by delaying notification of qualifying events. For example, in case of a divorced spouse, the employee may, for a variety of reasons, delay notification of the divorce to the employer. The spouse could then delay notification of election until such time as future medical needs arise. Such situations should be avoided in order to establish certainty under the act with regard to beneficiary rights and employer obligations. The amendment clearly provides that continuation begins on the date the qualifying event occurs and ends on the earliest to occur of the specified events stated in the law.

AMENDMENT 5 (Attached copy page 3)

Rationale: The existing provision specifies those circumstances or occurrences which cause the continuation of coverage as to a beneficiary to terminate; namely, 1) as to any beneficiary becoming covered under another group health plan as an employee, and 2) as to a spouse becoming covered under another group health plan through remarriage. Clearly, the Act was intended to provide termination of continuation when any beneficiary becomes covered under another group health plan regardless of how such coverage is provided. This intent is consistent with the termination of continued coverage when the beneficiary becomes covered through Medicare.

Without the changes indicated, the Act will permit duplication of coverages for some beneficiaries in a discriminatory way. For example, a beneficiary becoming covered under another group health plan other than as an employee would have duplicating coverages. Also a spouse becoming covered under another group health benefit plan other than through remarriage (for example, as an employee) would also have duplicating coverages.

The suggested amendments make the provisions consistent for all beneficiaries and provide for the termination of continued coverage when such beneficiary becomes covered under another group health plan whether through remarriage, reemployment or through any other circumstance.

For these reasons, the section "REMARRIAGE OF SPOUSE" is unnecessary and should be deleted. If not deleted it should be amended as indicated - the phrase "...through remarriage or otherwise" could remain if thought necessary to demonstrate responsiveness to the divorced spouse situations.

AMENDMENT 6 (Attached copy page 6)

Rationale: Under existing provisions, under certain circumstances, a qualified beneficiary can deliberately or otherwise delay indefinitely notification to the employer of the occurrence of a qualifying event, thus delaying indefinitely the period of time within which an election for continuation of coverage must be made. While it is recognized the Act inherently invites substantial anti-selection which will increase the costs of employer plans, the proposed amendment will tend to curtail overt manipulation and plan abuse and provide some degree of certainty regarding employer obligations and liabilities.

The suggested amendment makes it clear that the responsibility of the beneficiary for notifying the plan administrator is an essential one in order to be eligible for continuation of coverage. The amendment provides a period of 30 days within which such notification must be made. This period is consistent with the like period of time required for similar notification requirements on the part of the employer, and tend to prevent overt abuses of the Act.

AMENDMENT 7 (Attached copy page 7)

Rationale: Without the suggested deletion, this provision is confusing and subject to various interpretations. Literally, it would appear to extend the application of the Act to qualified events occurring without limitation in the past. Read literally, this provision could be interpreted to provide continuation rights as to an individual who had retired many years prior to this Act or impose as to the same beneficiary liability for continuation of coverage on the part of numerous employers with whom the beneficiary may have been previously employed. These results clearly are not intended under the Act, and the suggested amendment removes these ambiguities.

Amendments 8 through 13 are ERISA amendments parallel to IRC Amendments 2 through 7.

Amendments 14 through 19 are Public Health Service Act amendments parallel to IRC Amendments 2 through 7.

TITLE X--PRIVATE HEALTH INSURANCE COVERAGE

SEC. 10001. EMPLOYERS REQUIRED TO PROVIDE CERTAIN EMPLOYEES AND FAMILY MEMBERS WITH CONTINUED HEALTH INSURANCE COVERAGE AT GROUP RATES (INTERNAL REVENUE CODE AMENDMENTS).

(a) DENIAL OF DEDUCTION FOR EMPLOYER CONTRIBUTION TO PLAN.--Subsection (i) of section 162 of the Internal Revenue Code of 1954 (relating to deduction for trade or business expenses with respect to group health plans) is amended by redesignating paragraph (2) as paragraph (3) and by inserting after paragraph (1) the following new paragraph:

"(2) PLANS MUST PROVIDE CONTINUATION COVERAGE TO CERTAIN INDIVIDUALS.--

"(A) IN GENERAL.--No deduction shall be allowed under this section for expenses paid or incurred by an employer for any group health plan maintained by such employer unless all such plans maintained by such employer meet the continuing coverage requirements of subsection (k).

"(B) EXCEPTION FOR CERTAIN SMALL EMPLOYERS, ETC.--Subparagraph (A) shall not apply to any plan described in section 106(b)(2)."

(b) DENIAL OF EXCLUSION FOR HIGHLY COMPENSATED INDIVIDUALS.--Section 106 of the Internal Revenue Code of 1954 (relating to contributions by employer to accident and health plans) is amended by inserting "(a) IN GENERAL.--" before "Gross" and by inserting at the end thereof the following new subsection:

"(b) EXCEPTION FOR HIGHLY COMPENSATED INDIVIDUALS WHERE PLAN FAILS TO PROVIDE CERTAIN CONTINUATION COVERAGE.--

"(1) IN GENERAL.--Subsection (a) shall not apply to any amount contributed by an employer on behalf of a highly compensated individual (within the meaning of section 105(h)(5)) to a group health plan maintained by such employer unless all such plans maintained by such employer meet the continuing coverage requirements of section 162(k).

AMENDMENT 2

"(A) [group health plan for any calendar year if all employers maintaining such plan] employer normally [employed] employing fewer than 20 employees on a typical business day during the preceding calendar year,

AMENDMENT 3

a result of a qualifying event, and is not otherwise covered under another group health plan at the time such qualifying event occurs, is entitled to elect, within the election period, continuation coverage under the plan.

AMENDMENT 4

"(B) PERIOD OF COVERAGE.--The coverage [must extend for at least the period beginning] begins on the date of the qualifying event and [ending not earlier than] ends on the earliest of the following:

"(2) EXCEPTION FOR CERTAIN PLANS.--Paragraph (1) shall not apply to any--

"(A) group health plan for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year,

"(B) governmental plan (within the meaning of section 414(d), or

"(C) church plan (within the meaning of section 414(e)).

Under regulations, rules similar to the rules of subsections (a) and (b) of section 52 (relating to employers under common control) shall apply for purposes of subparagraph (A).

"(3) GROUP HEALTH PLAN.--For purposes of this subsection, the term 'group health plan' has the meaning given such term by section 162(i)(3)."

(c) CONTINUATION COVERAGE REQUIREMENTS.--Section 162 of the Internal Revenue Code of 1954 is amended by redesignating subsection (k) as subsection (l) and by inserting after subsection (j) the following new subsection:

"(k) CONTINUATION COVERAGE REQUIREMENTS OF GROUP HEALTH PLANS.--

"(1) IN GENERAL.--For purposes of subsection (i)(2) and section 106(b)(1), a group health plan meets the requirements of this subsection only if each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled to elect, within the election period, continuation coverage under the plan.

"(2) CONTINUATION COVERAGE.--For purposes of paragraph (1), the term 'continuation coverage' means coverage under the plan which meets the following requirements:

"(A) TYPE OF BENEFIT COVERAGE.--The coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred.

"(B) PERIOD OF COVERAGE.--The coverage must extend for at least the period beginning on the date of the

AMENDMENT 5

"(iv) [REEMPLOYMENT] NEW COVERAGE OR MEDICARE ELIGIBILITY.

"(I) [a] covered [employee] under any other group health plan, or

DELETE OR AMEND AS FOLLOWS:
"(v) REMARRIAGE OF SPOUSE.--In the case of an individual who is a qualified beneficiary by reason of being the spouse of a covered employee, the date on which the beneficiary [remarries and] becomes covered under a group health plan through remarriage or otherwise.

qualifying event and ending not earlier than the earliest of the following:

"(i) MAXIMUM PERIOD.--In the case of--

"(I) a qualifying event described in paragraph (3)(B) (relating to terminations and reduced hours), the date which is 18 months after the date of the qualifying event, and

"(II) any qualifying event not described in subclause (I), the date which is 36 months after the date of the qualifying event.

"(ii) END OF PLAN.--The date on which the employer ceases to provide any group health plan to any employee.

"(iii) FAILURE TO PAY PREMIUM.--The date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary.

"(iv) REEMPLOYMENT OR MEDICARE ELIGIBILITY.--The date on which the qualified beneficiary first becomes, after the date of the election--

"(I) a covered employee under any other group health plan, or

"(II) entitled to benefits under title XVIII of the Social Security Act.

"(v) REMARRIAGE OF SPOUSE.--In the case of an individual who is a qualified beneficiary by reason of being the spouse of a covered employee, the date on which the beneficiary remarries and becomes covered under a group health plan.

"(C) PREMIUM REQUIREMENTS.--The plan may require payment of a premium for any period of continuation coverage, except that such premium--

"(i) shall not exceed 102 percent of the applicable premium for such period, and

"(ii) may, at the election of the payor, be made in monthly installments. If an election is made after the qualifying event, the plan shall permit payment for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

"(D) NO REQUIREMENT OF INSURABILITY. --The coverage may not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

"(E) CONVERSION OPTION.--In the case of a qualified beneficiary whose period of continuation coverage expires under subparagraph (B)(i), the plan must, during the 180-day period ending on such expiration date, provide to the qualified beneficiary the option of enrollment under a conversion health plan otherwise generally available under the plan.

"(3) QUALIFYING EVENT.--For purposes of this subsection, the term 'qualifying event' means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this subsection, would result in the loss of coverage of a qualified beneficiary:

"(A) The death of the covered employee.

"(B) The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.

"(C) The divorce or legal separation of the covered employee from the employee's spouse.

"(D) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act.

"(E) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

"(4) APPLICABLE PREMIUM.--For purposes of this subsection--

"(A) IN GENERAL.--The term 'applicable premium' means, with respect to any period of continuation coverage of qualified beneficiaries, the cost to the plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid by the employer or employee).

"(B) SPECIAL RULE FOR SELF-INSURED PLANS.--To the extent that a plan is a self-insured plan--

"(i) IN GENERAL.--Except as provided in clause (ii), the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to a reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries which--

"(I) is determined on an actuarial basis, and

"(II) takes into account such factors as the Secretary may prescribe in regulations.

"(ii) DETERMINATION ON BASIS OF PAST COST.--If a plan administrator elects to have this apply, the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to--

"(I) the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period under subparagraph (C), adjusted by

"(ii) the percentage increase or decrease in the implicit price deflator of the gross national product (calculated by the Department of Commerce and published in the Survey of Current Business) for the 12-month period ending on the last day of the sixth month of such preceding determination period.

"(iii) CLAUSE (ii) NOT TO APPLY WHERE SIGNIFICANT CHANGE.--A plan administrator may not elect to have clause (ii) apply in any case in which there is any significant difference, between the determination period and the preceding determination period, in coverage under, or in employees covered by, the plan. The determination under the preceding sentence for any determination period shall be made at the same time as the determination under subparagraph (C).

"(C) DETERMINATION PERIOD.--The determination of any applicable premium shall be made for a period of 12 months and shall be made before the beginning of such period.

"(5) ELECTION.--For purposes of this subsection--

"(A) ELECTION PERIOD.--The term 'election period' means the period which--

"(i) begins not later than the date on which coverage terminates under the plan by reason of a qualifying event.

"(ii) is of at least 60 days' duration, and

"(iii) ends not earlier than 60 days after the later of--

"(I) the date described in clause (i), or

"(II) in the case of any qualified beneficiary who receives notice under paragraph (6)(D), the date of such notice.

"(B) EFFECT OF ELECTION ON OTHER BENEFICIARIES.--Except as otherwise specified in an election, any election by a qualified beneficiary described in clause (i)(I) or (ii) of paragraph (7)(B) shall be deemed to include an election of continuation coverage on behalf of any other qualified beneficiary who would lose coverage under the plan by reason of the qualifying event.

"(6) NOTICE REQUIREMENTS.--In accordance with regulations prescribed by the Secretary--

"(A) the group health plan shall provide, at the time of commencement of coverage under the plan, written notice to each covered employee and spouse of the employee (if any) of the rights provided under this subsection,

"(B) the employer of an employee under a plan must notify the plan administrator of a qualifying event described in subparagraph (A), (B), or (D) of paragraph (3) with respect to such employee within 30 days of the date of the qualifying event.

"(C) each covered employee or qualified beneficiary is responsible for notifying the plan administrator of the occurrence of any qualifying event described in subparagraph (C) or (E) of paragraph (3), and

"(D) the plan administrator shall notify--

"(i) in the case of a qualifying event described in subparagraph (A), (B), or (D) of paragraph (3), any qualified beneficiary with respect to such event, and

"(ii) in the case of a qualifying event described in subparagraph (C) or (E) of paragraph (3) where the covered employee notifies the plan administrator under subparagraph (C), any qualified beneficiary with respect to such event,

of such beneficiary's rights under this subsection.

AMENDMENT 6

"(C) each covered employee or qualified beneficiary, in order to be eligible for continuation of coverage, is responsibile for notifying the plan administrator of the occurrence of any qualifying event described in subparagraph (C) or (E) of paragraph (3) within 30 days of the date of the qualifying event, and

AMENDMENT 7

"(A) COVERED EMPLOYEE.--The term 'covered employee' means an individual who [is (or was) provided coverage under a group health plan by virtue of the individual's employment or previous employment with an employer] was, on the date a qualifying event occurs, covered under a group health plan as an employee or retiree.

For purposes of subparagraph (D), any notification shall be made within 14 days of the date on which the plan administrator is notified under subparagraph (B) or (C), whichever is applicable, and any such notification to an individual who is a qualified beneficiary as the spouse of the covered employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time such notification is made.

"(7) DEFINITIONS.--For purposes of this subsection--

"(A) COVERED EMPLOYEE.--The term 'covered employee' means an individual who is (or was) provided coverage under a group health plan by virtue of the individual's employment or previous employment with an employer.

"(B) QUALIFIED BENEFICIARY.--

"(i) IN GENERAL.--The term 'qualified beneficiary' means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan--

"(I) as the spouse of the covered employee, or

"(II) as the dependent child of the employee.

"(ii) SPECIAL RULE FOR TERMINATIONS AND REDUCED EMPLOYMENT.--In the case of a qualifying event described in paragraph (3)(B), the term 'qualified beneficiary' includes the covered employee.

"(C) PLAN ADMINISTRATOR.--The term 'plan administrator' has the meaning given the term 'administrator' by section 3(16)(A) of the Employee Retirement Income Security Act of 1974."

(d) CONFORMING AMENDMENT.--Paragraph (1) of section 162(i) is amended by striking out "GENERAL RULE" in the heading thereof and inserting in lieu thereof "COVERAGE RELATING TO END STAGE RENAL DISEASE".

(e) EFFECTIVE DATES.--

(1) GENERAL RULE.--The amendments made by this section shall apply to plan years beginning on or after July 1, 1986.

AMENDMENT 8 (Same as 3)

result of a qualifying event, and is not otherwise covered under another group health plan at the time such qualifying event occurs, is entitled, under the plan, to elect within the election period, continuation coverage under the plan.

AMENDMENT 9 (Same as 2)

Subsection (a) shall not apply to any [group health plan for any calendar year if all employers maintaining such plan] employer normally [employed] employing fewer than 20 employees on a

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.--In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of--

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) January 1, 1987.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

SEC. 10002. TEMPORARY EXTENSION OF COVERAGE AT GROUP RATES FOR CERTAIN EMPLOYEES AND FAMILY MEMBERS (ERISA AMENDMENTS).

(a) IN GENERAL.--Subtitle B of title I of the Employment Retirement Income Security Act of 1974 is amended by adding at the end thereof the following new part:

"PART 6-- CONTINUATION COVERAGE UNDER GROUP HEALTH PLANS.

"SEC. 601. PLANS MUST PROVIDE CONTINUATION COVERAGE TO CERTAIN INDIVIDUALS.

"(a) IN GENERAL.--The plan sponsor of each group health plan shall provide, in accordance with this part, that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the plan.

"(b) EXCEPTION FOR CERTAIN PLANS.--Subsection (a) shall not apply to any group health plan for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year. Under regulations, rules similar to the rules of subsections (a) and (b) of section 52 of the Internal Revenue Code of 1954 (relating to employers under common control) shall apply for purposes of this subsection.

"Section. 602. CONTINUATION COVERAGE.

"For purposes of section 601, the term 'continuation coverage' means coverage under the plan which meets the following requirements:

"(1) TYPE OF BENEFIT COVERAGE.--The coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred.

AMENDMENT 10 (Same as 4)

"(2) PERIOD OF COVERAGE.--The coverage [must extend for at least the period beginning] begins on the date of the qualifying event and [ending not earlier than] ends on the earliest of the following:

"(2) PERIOD OF COVERAGE.--The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

"(A) MAXIMUM PERIOD.--In the case of--

"(i) a qualifying event described in section 603(2) (relating to terminations and reduced hours), the date which is 18 months after the date of the qualifying event, and

"(ii) any qualifying event not described in clause (i), the date which is 36 months after the date of the qualifying event.

"(B) END OF PLAN.--The date on which the employer ceases to provide any group health plan to any employee.

"(C) FAILURE TO PAY PREMIUM.--The date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary.

AMENDMENT 11 (Same as 5)

"(D) [REEMPLOYMENT] NEW COVERAGE OR MEDICARE ELIGIBILITY.

"(D) REEMPLOYMENT OR MEDICARE ELIGIBILITY.--The date on which the qualified beneficiary first becomes, after the date of the election--

"(i) [a] covered [employee] under any other group health plan, or

"(i) a covered employee under any other group health plan, or

"(ii) entitled to benefits under title XVIII of the Social Security Act.

DELETE OR AMEND AS INDICATED

"(E) REMARRIAGE OF SPOUSE.--In the case of an individual who is a qualified beneficiary by reason of being the spouse of a covered employee, the date on which the beneficiary [remarries and] becomes covered under a group health plan through remarriage or otherwise.

date on which the beneficiary remarries and becomes covered under a group health plan.

"(3) PREMIUM REQUIREMENTS.--The plan may require payment of a premium for any period of continuation coverage, except that such premium--

"(A) shall not exceed 102 percent of the applicable premium for such period, and

"(B) may, at the election of the payor, be made in monthly installments. If an election is made after the qualifying event, the plan shall permit payment for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

"(4) NO REQUIREMENT OF INSURABILITY.--The coverage may not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

"(5) CONVERSION OPTION.--In the case of a qualified beneficiary whose period of continuation coverage expires under paragraph (2)(A), the plan must, during the 180-day period ending on such expiration date, provide to the qualified beneficiary the option of enrollment under a conversion health plan otherwise generally available under the plan.

"SEC. 603. QUALIFYING EVENT.

"For purposes of this part, the term 'qualifying event' means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this part, would result in the loss of coverage of a qualified beneficiary:

"(1) The death of the covered employee.

"(2) The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.

"(3) The divorce or legal separation of the covered employee from the employee's spouse.

"(4) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act.

"(5) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

"SEC. 604. APPLICABLE PREMIUM.

"For purposes of this part--

"(1) IN GENERAL.--The term 'applicable premium' means, with respect to any period of continuation coverage of qualified beneficiaries, the cost to the plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid by the employer or employee).

"(2) SPECIAL RULE FOR SELF-INSURED PLANS.--To the extent that a plan is a self-insured plan--

"(A) IN GENERAL.--Except as provided in subparagraph (B), the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to a reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries which--

"(i) is determined on an actuarial basis, and

"(ii) takes into account such factors as the Secretary may prescribe in regulations.

"(B) DETERMINATION ON BASIS OF PAST COST.--If an administrator elects to have this subparagraph apply, the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to--

"(i) the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period under paragraph (3), adjusted by

"(ii) the percentage increase or decrease in the implicit price deflator of the gross national product (calculated by the Department of Commerce and published in the Survey of Current Business) for the 12-month period ending on the last day of the sixth month of such preceding determination period.

"(C) SUBPARAGRAPH (B) NOT TO APPLY WHERE SIGNIFICANT CHANGE.--An administrator may not elect to have subparagraph (B) apply in any case in which there is any significant difference, between the determination period and the preceding determination period, in coverage under, or in employees covered by, the plan. The determination under the preceding sentence for any determination period shall be made at the same time as the determination under paragraph (3).

"(3) DETERMINATION PERIOD.--The determination of any applicable premium shall be made for a period of 12 months and shall be made before the beginning of such period.

"SEC. 605. ELECTION.

"For purposes of this part--

"(1) ELECTION PERIOD.--The term 'election period' means the period which--

"(A) begins not later than the date on which coverage terminates under the plan by reason of a qualifying event,

"(B) is of at least 60 days' duration, and

"(C) ends not earlier than 60 days after the later of--

"(i) the date described in subparagraph (A), or

"(ii) in the case of any qualified beneficiary who receives notice under section 606(4), the date of such notice.

"(2) EFFECT OF ELECTION ON OTHER BENEFICIARIES.--Except as otherwise specified in an election, any election by a qualified beneficiary described in subparagraph (A)(i) or (B) of section 607(3) shall be deemed to include an election of continuation coverage on behalf of any other qualified beneficiary who would lose coverage under the plan by reason of the qualifying event.

"SEC. 606. NOTICE REQUIREMENTS.

"In accordance with regulations prescribed by the Secretary--

"(1) the group health plan shall provide, at the time of commencement of coverage under the plan, written notice to each covered employee and spouse of the employee (if any) of the rights provided under this subsection,

"(2) the employer of an employee under a plan must notify the administrator of a qualifying event described in paragraph (1), (2), or (4) of section 603 within 30 days of the date of the qualifying event,

AMENDMENT 12 (Same as 5)

"(3) each covered employee or qualified beneficiary, in order to be eligible for continuation of coverage, is responsible for notifying the administrator of the occurrence of any qualifying event described in paragraph (3) or (5) of section 603 within 30 days of the date of the qualify event, and

AMENDMENT 13 (Same as 7)

"(2) COVERED EMPLOYEE.--The term 'covered employee' means an individual who [is (or was) provided coverage under a group health plan by virtue of the individual's employment or previous employment with an employer] was, on the date a qualifying event occurs, covered under a group health plan as an employee or retiree.

"(3) each covered employee or qualified beneficiary is responsible for notifying the administrator of the occurrence of any qualifying event described in paragraph (3) or (5) of section 603, and

"(4) the administrator shall notify--

"(A) in the case of a qualifying event described in paragraph (1), (2), or (4) of section 603, any qualified beneficiary with respect to such event, and

"(B) in the case of a qualifying event described in paragraph (3) or (5) of section 603 where the covered employee notifies the administrator under paragraph (3), any qualified beneficiary with respect to such event, of such beneficiary's rights under this subsection.

For purposes of paragraph (4), any notification shall be made within 14 days of the date on which the administrator is notified under paragraph (2) or (3), whichever is applicable, and any such notification to an individual who is a qualified beneficiary as the spouse of the covered employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time such notification is made.

"SEC. 607. DEFINITIONS.

"For purposes of this part--

"(1) GROUP HEALTH PLAN.--The term 'group health plan' means an employee welfare benefit plan that is a group health plan (within the meaning of section 162(i)(3) of the Internal Revenue Code of 1954).

"(2) COVERED EMPLOYEE.--The term 'covered employee' means an individual who is (or was) provided coverage under a group health plan by virtue of the individual's employment or previous employment with an employer.

"(3) QUALIFIED BENEFICIARY.--

"(A) IN GENERAL.--The term 'qualified beneficiary' means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan--

"(i) as the spouse of the covered employee, or

"(ii) as the dependent child of the employee.

"(B) SPECIAL RULE FOR TERMINATIONS AND REDUCED EMPLOYMENT.--In the case of a qualifying event described in section 603(2), the term 'qualified beneficiary' includes the covered employee."

"SEC. 608. REGULATIONS.

"The Secretary may prescribe regulations to carry out the provisions of this part."

(b) PENALTY FOR FAILURE TO PROVIDE NOTICE.--Section 502(c) of such Act (29 U.S.C. 1132(C)) is amended by inserting after "Any administrator" the following: "(1) who fails to meet the requirements of paragraph (1) or (4) of section 606 with respect to a participant or beneficiary, or (2)".

(c) CLERICAL AMENDMENTS.--The table of contents in section 1 of such Act is amended by inserting after the item relating to section 514 the following new items:

"PART 6-- CONTINUATION COVERAGE UNDER GROUP HEALTH PLANS

"Sec. 601. Plans must provide continuation coverage to certain individuals.
"Sec. 602. Continuation coverage.
"Sec. 603. Qualifying event.
"Sec. 604. Applicable premium.
"Sec. 605. Election.
"Sec. 606. Notice requirements.
"Sec. 607. Definitions.
"Sec. 608. Regulations."

(d) EFFECTIVE DATES.--

(1) GENERAL RULE.--The amendments made by this section shall apply to plan years beginning on or after July 1, 1986.

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.--In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of--

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act) or

(B) January 1, 1987.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

(e) NOTIFICATION TO COVERED EMPLOYEES.--At the time that the amendments made by this section apply to a group health plan (within the meaning of section 607(1) of the Employee Retirement Income Security Act of 1974), the plan shall notify each covered employee, and spouse of the employee (if any), who is covered under the plan at that time of the continuation coverage requirement under part 6 of subtitle B of title I of such Act. The notice furnished under this subsection is in lieu of notice that may otherwise be required under section 606(1) of such Act with respect to such individuals.

SEC. 10003. CONTINUATION OF HEALTH INSURANCE FOR STATE AND LOCAL EMPLOYEES WHO LOST EMPLOYMENT-RELATED COVERAGE (PUBLIC HEALTH SERVICE ACT AMENDMENTS).

(a) IN GENERAL.--The public Health Service Act is amended by adding at the end the following new title:

"TITLE XXII--REQUIREMENTS FOR CERTAIN GROUP HEALTH PLANS FOR CERTAIN STATE AND LOCAL EMPLOYEES

"SEC. 2201. STATE AND LOCAL GOVERNMENTAL GROUP HEALTH PLANS MUST PROVIDE CONTINUATION COVERAGE TO CERTAIN INDIVIDUALS.

"(a) IN GENERAL.--In accordance with regulations which the Secretary shall prescribe, each group health plan that is maintained by any State that receives funds under this Act, by any political subdivision of such a State,

AMENDMENT 14 (Same as 3)

as a result of a qualifying event, and is not otherwise covered under another group health plan at the time such qualifying event occurs, is entitled, under the plan, to elect, within the election period, continuation coverage under the plan.

AMENDMENT 15 (Same as 2)

"(1) [any group health plan for any calendar year if all employers maintaining such plan] employer normally [employed] employing fewer than 20 employees on a typical business day during the preceding calendar year, or

AMENDMENT 16 (Same as 4)

"(2) PERIOD OF COVERAGE.--The coverage [must extend for at least the period beginning] begins on the date of the qualifying event and [ending not earlier than] ends on the earliest of the following:

or by any agency or instrumentality of such a State or political subdivision, shall provide, in accordance with this title, that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the plan.

"(b) EXCEPTION FOR CERTAIN PLANS.--Subsection (a) shall not apply to--

"(1) any group health plan for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year, or

"(2) any group health plan maintained for employees by the government of the District of Columbia or any territory or possession of the United States or any agency or instrumentality.

Under regulations, rules similar to the rules of subsections (a) and (b) of section 52 of the Internal Revenue Code of 1954 (relating to employers under common control) shall apply for purposes of paragraph (1).

"SEC. 2202. CONTINUATION COVERAGE.

"For purposes of section 2201, the term 'continuation coverage' means coverage under the plan which meets the following requirements:

"(1) TYPE OF BENEFIT COVERAGE.--The coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred.

"(2) PERIOD OF COVERAGE.--The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

"(A) MAXIMUM PERIOD.--In the case of--

"(i) a qualifying event described in section 2203(2) (relating to terminations and reduced hours), the date which is 18 months after the date of the qualifying event, and

"(ii) any qualifying event not described in clause (i), the date which is 36 months after the date of the qualifying event.

AMENDMENT 17 (Same as 5)

"(D) [REEMPLOYMENT] NEW COVERAGE OR MEDICARE ELIGIBILITY.

"(i) [a] covered [employee] under any other group health plan, or

DELETE OR AMEND AS FOLLOWS

"(E) REMARRIAGE OF SPOUSE.--In the case of an individual who is a qualified beneficiary by reason of being the spouse of a covered employee, the date on which the beneficiary [remarries and] becomes covered under a group health plan through remarriage or otherwise.

"(B) END OF PLAN.--The date on which the employer ceases to provide any group health plan to any employee.

"(C) FAILURE TO PAY PREMIUM.--The date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary.

"(D) REEMPLOYMENT OR MEDICARE ELIGIBILITY.--The date on which the qualified beneficiary first becomes, after the date of the election--

"(i) a covered employee under any other group health plan, or

"(ii) entitled to benefits under title XVIII of the Social Security Act.

"(E) REMARRIAGE OF SPOUSE.--In the case of an individual who is a qualified beneficiary by reason of being the spouse of a covered employee, the date on which the beneficiary remarries and becomes covered under a group health plan.

"(3) PREMIUM REQUIREMENTS.--The plan may require payment of a premium for any period of continuation coverage, except that such premium--

"(A) shall not exceed 102 percent of the applicable premium for such period, and

"(B) may, at the election of the payor, be made in monthly installments. If an election is made after the qualifying event, the plan shall permit payment for continuation coverage during the period continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

"(4) NO REQUIREMENT OF INSURABILITY.--The coverage may not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

"(5) CONVERSION OPTION.--In the case of a qualified beneficiary whose period of continuation coverage expires under paragraph (2)(A), the plan must, during the 180-day period ending on such expiration date, provide to the qualified beneficiary the option of enrollment under a conversion health plan otherwise generally available under the plan.

"SEC. 2203. QUALIFYING EVENT.

"For purposes of this title, the term 'qualifying event' means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this title, would result in the loss of coverage of a qualified beneficiary.

"(1) The death of the covered employee.

"(2) The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.

"(3) The divorce or legal separation of the covered employee from the employee's spouse.

"(4) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act.

"(5) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

"SEC. 2204. APPLICABLE PREMIUM.

"For purposes of this title--

"(1) IN GENERAL.--The term 'applicable premium' means, with respect to any period of continuation coverage of qualified beneficiaries, the cost to the plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid by the employer or employee).

"(2) SPECIAL RULE FOR SELF-INSURED PLANS.--To the extent that a plan is a self-insured plan--

"(A) IN GENERAL.--Except as provided in subparagraph (B), the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to a reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries which--

"(i) is determined on an actuarial basis, and

"(ii) takes into account such factors as the Secretary may prescribe in regulations.

"(B) DETERMINATION ON BASIS OF PAST COST.--If a plan administrator elects to have this subparagraph apply, the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to--

"(i) the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period under paragraph (3), adjusted by

"(ii) the percentage increase or decrease in the implicit price deflator of the gross national product (calculated by the Department of Commerce and published in the Survey of Current Business) for the 12-month period ending on the last day of the sixth month of such preceding determination period.

"(C) SUBPARAGRAPH (B) NOT TO APPLY WHERE SIGNIFICANT CHANGE.--A plan administrator may not elect to have subparagraph (B) apply in any case in which there is any significant difference, between the determination period and the preceding determine action period, in coverage under, or in employees covered by, the plan. The determination under the preceding sentence for any determination period shall be made at the same time as the determination under paragraph (3).

"(3) DETERMINATION PERIOD.--The determination of any applicable premium shall be made for a period of 12 months and shall be made before the beginning of such period.

"SEC. 2205. ELECTION.

"For purposes of this title--

"(1) ELECTION PERIOD.--The term 'election period' means the period which--

"(A) begins not later than the date on which coverage terminates under the plan by reason of a qualifying event,

"(B) is of at least 60 days' duration, and

"(C) ends not earlier than 60 days after the later of--

"(i) the date described in subparagraph (A), or

"(ii) in the case of any qualified beneficiary who receives notice under section 2206(4), the date of such notice.

"(2) EFFECT OF ELECTION ON OTHER BENEFICIARIES.--Except as otherwise specified in an election, any election by a qualified beneficiary described in subparagraph (A)(i) or (B) of section 2208(3) shall be deemed to include an election of continuation coverage on behalf of any other qualified beneficiary who would lose coverage under the plan by reason of the qualifying event.

"SEC. 2206. NOTICE REQUIREMENTS.

"In accordance with regulations prescribed by the Secretary--

"(1) the group health plan shall provide, at the time of commencement of coverage under the plan, written notice to each covered employee and spouse of the employee (if any) of the rights provided under this subsection,

"(2) the employer of an employee under a plan must notify the plan administrator of a qualifying event described in paragraph (1), (2), or (4) of section 2203 within 30 days of the date of the qualifying event;

"(3) each covered employee or qualified beneficiary is responsible for notifying the plan administrator of the occurrence of any qualifying event described in paragraph (3) or (5) of section 2203, and

"(4) the plan administrator shall notify--

"(A) in the case of a qualifying event described in paragraph (1), (2), or (4) of section 2203, any qualified beneficiary with respect to such event, and

"(B) in the case of a qualifying event described in paragraph (3) or (5) of section 2203 where the covered employee notifies the plan administrator under paragraph (3), any qualified beneficiary with respect to such event,

of such beneficiary's rights under this subsection.

For purposes of paragraph (4), any notification shall be made within 14 days of the date on which the plan administrator is notified under paragraph (2) or (3), whichever is applicable, and any such notification to an individual who is a qualified beneficiary as the spouse of the covered employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time such notification is made.

AMENDMENT 18 (Same as 6)

"(3) each covered employee or qualified beneficiary, in order to be eligible for continuation of coverage, is responsible for notifying the plan administrator of the occurrence of any qualifying event described in paragraph (3) or (5) of section 2203, within 30 days of the date of the qualifying event, and

AMENDMENT 19 (Same as 7)

"(2) COVERED EMPLOYEE.--The term 'covered employee' means an individual who [is (or was) provided coverage under a group health plan by virtue of the individual's employment or previous employment with an employer] was, on the date a qualifying event occurs, covered under a group health plan as an employee or retiree.

"SEC. 2207. ENFORCEMENT.

"Any individual who is aggrieved by the failure of a State, political subdivision, or agency or instrumentality thereof, to comply with the requirements of this title may bring an action for appropriate equitable relief.

"SEC. 2208. DEFINITIONS.

"For purposes of this title--

"(1) GROUP HEALTH PLAN.--The term 'group health plan' has the meaning given such term in section 162(i)(3) of the Internal Revenue Code of 1954.

"(2) COVERED EMPLOYEE.--The term 'covered employee' means an individual who is (or was) provided coverage under a group health plan by virtue of the individual's employment or previous employment with an employer.

"(3) QUALIFIED BENEFICIARY.--

"(A) IN GENERAL.--The term 'qualified beneficiary' means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan--

"(i) as the spouse of the covered employee, or

"(ii) as the dependent child of the employee.

"(B) SPECIAL RULE FOR TERMINATIONS AND REDUCED EMPLOYMENT.--In the case of a qualifying event described in section 2203(2), the term 'qualified beneficiary' includes the covered employee.

"(4) PLAN ADMINISTRATOR.--The term 'plan administrator' has the meaning given the term 'administrator' by section 3(16)(A) of the Employee Retirement Income Security Act of 1974."

(b) EFFECTIVE DATES.--

(1) GENERAL RULE.--The amendments made by this section shall apply to plan years beginning on or after July 1, 1986.

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.--In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of

the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of--

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) January 1, 1987.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

(c) NOTIFICATION TO COVERED EMPLOYEES.-- At the time that the amendments made by this section apply to a group health plan (covered under section 2201 of the Public Health Service Act), the plan shall notify each covered employee, and spouse of the employee (if any), who is covered under the plan at that time of the continuation coverage required under title XXII of such Act. The notice furnished under this subsection is in lieu of notice that may otherwise be required under section 2206(1) of such Act with respect to such individuals.

USX

Honorable Orrin G. Hatch
U. S. Senate
Russell Senate Office Building
Room SR-135
Washington, D.C. 20510

July 16, 1986

Dear Senator Hatch:

We appreciate the opportunity to comment on S. 2402, "Access to Health Care Act of 1986." The bill is of great concern to us.

This bill alarms us in two areas:

1. Federal Government mandating of benefits, and
2. Further dumping of government responsibility costs onto employers.

First, the mandating of benefits by the federal government is an infringement on the collective bargaining relationships of employers and employees. Why should government tell employees that they should forego a type of compensation or benefit that they choose so that the employer can pay for a benefit mandated by the government? Employers have had to fight state legislation of this type for years. This particular legislation deals with extension of coverage and who pays for it, but the next mandate will be dental coverage, or legal, or vision, or chiropractors, or psychologists, etc. as each provider group sells its wares. As we all know, there is no free lunch. Each item mandated by government will displace some other element of compensation, or it will increase product cost and weaken that employer's competitive position relative to domestic or foreign suppliers.

The second issue concerns who pays the bill. This bill appears to be an open door for spending with no control over quantity of services, nor the price of the services, and it may be an indirect, backdoor approach to a State segmented National Health Program. We offer the following questions as a means of focusing on a number of critical issues in the present Bill that need much more thoughtful study before this legislation injures the goal it attempts to serve.

Marathon Oil Company
USS Inc.
U.S. Diversified Group
Texas Oil & Gas Corp.

1. Why should business pay for uncompensated care?
   Why don't the Bill's sponsors acknowledge plainly to the country that they are adding another tax on business which will either pass on to consumers in higher product cost masked as inflation, or more jobs eliminated -- there are no other possible consequences.

2. Do the sponsors and the Congress really understand that uncompensated care includes a broad range of elements?
   - Underpayment of actual cost by Medicaid?
   - Medicaid eligibility requiring destitution for coverage?
   - Deliberate choice of many employed families to gamble on good health?
   - Failure to pay deductibles and co-payments?
   - Minimal coverage insurance policies that can't handle big hospital bills?
   - Leading edge technology performed on patients not having coverage at all or not covered for experimental treatment?
   - Uninsured?
   - Unable or unwilling to work?

3. Isn't medical insurance already available to everyone regardless of pre-existing conditions during Blue Cross open enrollments? If yes, what is the purpose of another risk pool when Blue Cross already provides one? If the risk pool is to be actuarially self-supporting, what is the purpose of a 10% surcharge on big companies?

4. Is it the objective of the plan sponsors to move the country to a National Health Program?
   Doesn't this bill provide an unlimited flow of funds to hospitals and physicians -- groups that have demonstrated over and over their ability to spend without limit and without significant improvement in results? Doesn't this approach have all the bad features of a National Health Program without even the small virtue of regulatory controls?

5. Has the probability been considered that fewer people will use their own resources to purchase medical insurance when it becomes apparent that they are assured top tier medical care because someone else will pay the bill?

6. Has the proliferation of medical services that will be added through this legislation been estimated?
Have the services per participant under free Medicaid coverage been compared to those delivered to uninsured people?
Has any analysis been done in the States which have implemented programs for financing uncompensated care to determine the rate of increase in services consumed, and the cost?
How have these increased services impacted health outcome?

7. Why should large employers (20 or more employees) incur a big cost increase because they already provide expensive coverage for their employees, yet small employers who most often provide little or no coverage, escape scot-free?
Why does the bill insist on economically punishing those employers who now do the most for their employees' health care cost?

8. If private employers in a State are forced to pay a surcharge and enter a risk pool, why are government employers excluded?

9. Why should a generous employer who already provides company paid medical benefits after layoff for an additional two years now be forced to pay four months more, but the employer who provides no insurance pays nothing?
Again, this punishes those who already do the most for their employees.

It appears that the Congress is attempting to dump a bigger load of government responsibility cost onto an employer's product cost, thus damaging its competitive position. If we can't sell our products, everybody is failed - tax gatherers, investors, pension funds, and lenders and the prospective recipient of badly designed aid. When government legislates benefits with the costs borne by employers, it circumvents the basic control of raising the revenue through taxes to pay for its actions.

Thank you for the opportunity to express our views. This subject is of critical importance to us. Rapidly escalating health care costs for active employees, laid off employees and retirees, all including spouses and dependents, threaten to overwhelm employers and destroy jobs. We urge that legislators not proceed down this path of mandating benefits and dumping government responsibilities onto employers.

Yours very truly,

JD Short

J. D. Short
Vice President
Benefits Administration

cc: Members of Senate Labor and
Human Resources Committee

U.S. SMALL BUSINESS ADMINISTRATION
WASHINGTON, D.C. 20416

OFFICE OF CHIEF COUNSEL FOR ADVOCACY

July 16, 1986

The Honorable Orrin Hatch
Chairman
Committee on Labor and Human Resources
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I appreciate the fact that the Committee on Labor and Human Resources is conducting a hearing on "Barriers to Health Care." As the Chief Counsel for Advocacy of the Small Business Administration (SBA), I am particularly interested in the costs of health care to small firms and how more small companies can obtain affordable benefits for their employees. For this reason I would like to address provisions of S.2402, the "Access to Health Care Act of 1986," that directly affect small business health coverage and will be discussed at the hearing.

Basically, the Office of Advocacy supports sections of the bill that address the needs of small business, including demonstration projects on ways to lower health care costs, and parity in tax deductions for self-employed individuals.[1] We strongly question other provisions of S.2402 which would adversely affect the ability of small firms to provide health benefits. These include the taxation of companies with employment-based health plans for purposes of funding statewide risk pools, and the continuation of employer contributions for laid off workers.

I will first discuss section 5, which addresses the need to reduce the costs of health care for small business employers and the self-employed. This discussion can then be used as a reference for subsequent analyses of sections 2, and 4, which are of concern to small businesses.

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[1] S.2402 does not contain a tax deduction for the self-employed, however, its companion bill, S.2403, as well as the Senate tax bill, H.R. 3838, both provide for such a deduction.

DEMONSTRATION PROJECTS FOR SMALL BUSINESS AND SELF-EMPLOYED PERSONS

This bill requires the Department of Health and Human Services (DHHS) to conduct studies and demonstration projects on ways to lower health care costs to small employers and self-employed individuals, focusing on savings in marketing and administrative costs. Findings are to be reported to Congress by January 1988.

Increasing health care coverage in small businesses is important because research indicates that health coverage decreases as firm size decreases, most notably in businesses with fewer than 100 employees. Less than half of small firms' employees are provided health coverage, compared to 86 percent coverage in large businesses.

Self-employed individuals and their employees are even less likely to have employer-sponsored health plans. Approximately 7.3 million firms are classified as full-time, unincorporated self-employed. Only 28 percent of these self-employed firms were covered by their own or a group health plan in 1982. If indirect coverage, such as a spouse's plan, is considered, then 46 percent received health insurance, leaving about 4 million firms without coverage.

The main reason for the lower health care coverage in small companies, including the self-employed, is that they generally must pay more for comparable health benefits than large businesses. There are many reasons for this.[2] One major reason is the trend among large companies to keep costs down by self-insuring. Self-insurance not only lowers administrative costs for the employer, but also usually exempts them from the increasing costs imposed by various mandated benefits in most states. Self-insurance is not a viable alternative for a firm that has only a few employees among which to spread risk.

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[2] See enclosed SBA Issue Alert Small Business and Health Care: Providing Affordable Benefits, April 1986, for greater detail.

Although there has been an increase in competition among providers and insurers, efforts have been concentrated on large corporations' health care needs. Business and health coalitions have sprung up in almost every state, but preliminary analysis of a survey of these groups shows that the majority are composed primarily of large business members and have little knowledge about small firm health plans. For example, most membership fees are not tiered and preclude small firms from joining. Furthermore, efforts to contain costs on the part of coalitions tend to focus on methods that are feasible for bigger companies, e.g., utilization review.

Scattered throughout the country are examples of innovative ways small firms are obtaining reasonably priced insurance, however, there is no mechanism for evaluating which plans are most effective, nor is there a systematic sharing of information on approaches that help small business offer health plans or contain costs as large firms are able to do.

The Office of Advocacy supports an in-depth examination of existing and potential ways that small firms can provide health benefits to workers. Demonstration projects can improve access to health care for small business employers, the self-employed, and their workers.

PARITY IN HEALTH BENEFIT DEDUCTIONS

The Office of Advocacy also supports the proposed tax deduction for self-employed individuals (also included in the Senate tax bill, H.R. 3838), who under current law are unable to deduct from their taxes any portion of their health insurance premiums as a business expense. Allowing the self-employed this tax favored treatment will not only place them on equal footing with incorporated firms, but also it will encourage extended health coverage of self-employed owners and their workers.

STATEWIDE INSURANCE RISK POOLS

Section 2, of the proposed "Access to Health Care Act of 1986" provides incentives for the establishment of statewide insurance pools for people who do not have access to employment-based health insurance and for various reasons do not have individual policies. The bill provides that if the premiums charged to individuals seeking coverage do not cover losses, all firms with twenty or more employees that offer employment-based health insurance would be assessed to make up the difference.

Although it is important to address the problems of the uninsured and individuals suffering from catastrophic illnesses, this proposal is both premature and would impose a hardship on small firms with less than one hundred but more than twenty employees. Enactment of this proposal is premature since there is currently a year long study on financing options for catastrophic coverage underway at the Department of Health and Human Services. The results of this study should be considered before any new legislation is adopted.

In addition, the benefits of requiring statewide risk pools are also uncertain. As was noted by several experts at a recent policy conference on state health insurance risk pools, mandating such programs will only assist a small percentage of the uninsured. Six states currently operate risk pools, yet only a small fraction of the uninsured within each state participates. Rather than impose a sweeping Federal law that requires states to set up pools, states should be permitted to choose this alternative, or establish other ways to assist uninsured persons as they see fit.

Finally, for reasons outlined above, small businesses with less than 100 workers are less likely to provide health coverage than their larger counterparts. An assessment--especially one that cannot be controlled for since costs would be unknown--on the health plans of these companies that do have plans may cause them to discontinue benefits. The added cost may also discourage those firms that are contemplating starting up a plan from doing so. Taxing employer-based health plans for state risk pools is inequitable and a poor incentive for small businesses to provide health benefits.

EXTENSION OF COVERAGE FOR LAID OFF WORKERS

We oppose section 4 of S.2402, which expands the continuation coverage requirements enacted in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The proposed bill expands the length of time for continuation coverage for terminated employees from 18 to 22 months. In addition, the employer's contribution to premium payments is extended; employers with twenty or more employees that offer health plans would be required to extend coverage for four months after a worker is laid off, with the employer continuing to pay the same contribution he/she was paying prior to the lay-off. A third requirement allows for open enrollment for family coverage when a worker in a two-worker family is laid off and loses health insurance.

At the payroll cost session of the regional White House Small Business Conference in Washington, D.C. on June 10, a delegate observed that following increased pension regulation in the mid-1970s, thousands of small firms dropped this employee benefit. Many other small business owners attending White House Small Business Conferences compared this example to what is likely to happen as the Federal Government attempts to shift more and more responsibility for health care costs to employers. An unintended consequence of mandated continuation coverage may result; fewer total persons, rather than more individuals such as the unemployed will be covered, because small business employers cannot afford to pay for an ever widening circle of specific uncovered groups. One of the top recommendations coming out of all White House Small Business Conferences is to reject any federally mandated benefits, notably in the area of health care.

It is unreasonable to expand the requirements of COBRA even further before the law's impact on employers can be assessed. Small business owners throughout the country were shocked to learn of new requirements imposed by COBRA on the administration of their health plans, effective July 1. It is important that sufficient time be permitted to assess the cumulative effects of Federal and state mandated health benefits before additional requirements are enacted.

I realize that the medically uninsured and underinsured is a serious problem our nation is facing. Employers, especially small business employers, must strive to provide health benefits to workers with broad coverage. Yet to mandate benefits that employers must include in their plans, or specific groups that employers must cover will only exacerbate problems small businesses already encounter.

I appreciate the opportunity to provide information on the small business perspective with respect to S.2402. We are prepared to offer further assistance to the Committee if this legislation progresses. This letter represents only the views of the Office of the Chief Counsel for Advocacy and are not necessarily those of the Administration.

Yours very truly,

Frank S. Swain

Frank S. Swain
Chief Counsel for Advocacy

Enclosure

STATEMENT

BY

THE ASSOCIATED GENERAL CONTRACTORS OF AMERICA

TO

SENATE LABOR AND HUMAN RESOURCES COMMITTEE

ON S. 2402

"THE ACCESS TO HEALTH CARE ACT

OF 1986"

AS A

BARRIER TO HEALTH CARE

AGC is:

- More than 32,500 firms, including 8,400 of America's leading general construction contractors, responsible for the employment of over 3,400,000 individuals;
- 108 chapters throughout the 50 states, the District of Columbia and Puerto Rico;
- More than 80 percent of America's contract construction of commercial buildings, highways, and industrial and municipal utility facilities.

The Associated General Contractors of America (AGC) is pleased to comment on S. 2402, the Access to Health Care Act of 1986.

S. 2402 would require employers to continue health insurance coverage for laid-off workers and their dependents for up to four months. The provisions of S. 2402 would be impractical and unworkable in the construction industry.

The construction industry employment relationship is temporary and intermittent and mirrors the project-by-project operations which prevail in the industry. Employees laid-off by one employer, because the project is complete, generally find employment with another employer whose project is just starting. Employees may work for several employers during the course of a year.

Periodic cyclical, seasonal, or between jobs unemployment is a reality in the construction industry. Both wage rates and fringe benefit programs, including health insurance, have been established to address the uniqueness of the construction employer relationship. High wage rates paid to construction workers, as compared to other industries, are a recognition of the potential for periods of unemployment. Similarly, construction fringe benefit programs, including health insurance programs, have also been designed to address the realities of the construction employment relationship.

Enactment of S. 2402 would be unworkable in the construction industry for the following reasons:

- Since employees work for different employers during the course of a year, each employer would have to provide for extended health insurance coverage through a single or multi-employer plan. The transient and mobile nature of construction operations makes it impossible to know when a former employee is now working on another project for another employer who is also providing health care coverage. Employees in some circumstances, and in certain trades, could have multiple employers paying for extended health insurance coverage as a result of S. 2402.

- Existing health insurance plans would be forced to revamp acturial schedules since each employer would have a potential liability for four months of continued coverage for all laid-off employees even though the mandatory four months of coverage could have no relationship to actual periods of unemployment.

- The administrative costs of implementing the provisions of S. 2402 would be astronomical in the construction industry. The result will be increased health insurance costs with little, if any, benefit for covered employees.

- S. 2402 creates an even broader problem-that of duplication, since many states have mandated benefit laws some of which encompass extension of health care benefits. This is an especially difficult problem in the construction industry since employers and employees in construction often work in different states.

- The recently passed Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers to continue to make available health plan coverage to various catagories of former employees and family members for periods ranging from 18 to 36 months. Much confusion has already resulted from the imposition of COBRA's requirements upon employers and states which have mandated benefit laws. It is imperative that sufficient time be permitted to assess the cumulative effects of COBRA before additional requirements are enacted.

AGC believes that the construction industry should be exempted from the provisions of S. 2402.

NATIONAL ASSOCIATION OF PUBLIC HOSPITALS 1426 Twenty-First Street, N.W., Suite 10, Washington, D.C. 20036 (202) 861-0434

Denver General Hospital
Boston City Hospital
District of Columbia General Hospital
Harris County Hospital District (Houston)
University of Medicine and Dentistry of New Jersey University Hospital
Grady Memorial Hospital (Atlanta)
Cleveland Metropolitan General Hospital
Santa Clara Valley Medical Center (San Jose)
The Los Angeles County Hospitals
Parkland Memorial Hospital (Dallas)
Truman Medical Center (Kansas City)
San Francisco General Hospital
Bellevue Hospital Center
Bronx Municipal Hospital
Cook County Hospital
Contra Costa County Health Services Department
Brackenridge Hospital (Austin)
Wishard Memorial Hospital (Indianapolis)
Chope Community Hospital (San Mateo)
Worcester City Hospital
Alameda County Health Care Services Agency (Oakland)
Westchester County Medical Center
Milwaukee County Medical Complex
Nassau County Medical Center
Regional Medical Center at Memphis
Pacific Medical Center (Seattle)
University of New Mexico Hospital
Harborview Medical Center University of Washington
Fresno County Valley Medical Center
General Hospital Ventura County
R.E. Thomason General Hospital (El Paso)
Kern Medical Center (Bakersfield)
University of Cincinnati Hospital
University of Texas Medical Branch
Queens Hospital Center
Hurley Medical Center (Flint)
San Bernardino County Medical Center
San Joaquin General Hospital (Stockton)
Riverside General Hospital University Medical Center
Oregon Health Sciences University Hospital
Spartanburg General Hospital (Spartanburg, SC)
Harlem Hospital Center
Charity Hospital of Louisiana
Maricopa Medical Center (Phoenix)
St. Louis County Hospital
Memorial Medical Center (Savannah, GA)
Amarillo Hospital District
Jackson Memorial Hospital (Miami)
Pontiac General Hospital (Pontiac, MI)
Clinton Memorial Hospital (Wilmington, OH)
Earl K. Long Memorial Hospital (Baton Rouge)

STATEMENT OF HOWARD N. NEWMAN,
SPECIAL COUNSEL
NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

BEFORE THE
LABOR AND HUMAN RESOURCES COMMITTEE
UNITED STATES SENATE

July 16, 1986

Mr. Chairman, members of the Subcommittee, I am Howard Newman, Special Counsel of the National Association of Public Hospitals (NAPH). On behalf of the 50 public hospitals and hospital systems around the country which now comprise the membership of NAPH, I appreciate this opportunity to testify today on the subject of access to health care for all Americans. Our member hospitals serve as the health safety net for all uninsured persons in many of our nation's metropolitan areas today.

I would first like to describe the situation of public hospitals generally, and then comment specifically on Senate bill S.2043 - "Access to Health Care Act of 1986."

The Situation of Public Hospitals Today

NAPH has described our nation's public hospital system in considerable detail in previous testimony before this Committee. However, I believe it is appropriate in the context of this hearing to call your attention again to several key service delivery and financing elements common to America's "safety net" hospitals and direct your attention to a number of new studies which shed further light on the role and situation of public hospitals today.

This nation has repeatedly considered enacting National Health Insurance and it may yet be possible for us to design "solutions" for the problem of uncompensated care that permit all of our nation's citizens access to needed health care. Until that time, however, we must acknowledge that there presently exists a nationwide network of institutions, a mere handful of metropolitan area public and private hospitals, that provide many of the services needed and used today by uninsured individuals. We believe the federal government must take steps to protect and preserve that network. Improving insurance coverage for even small segments of this population, and providing additional financial support for hospital charity care, will help alleviate the increasing burden on large urban public hospitals.

With regard to specific data in support of this general observation, NAPH has conducted and analyzed other new surveys and analyzed new data in the last several months to augment the information we have provided to this Committee in the past. we have conducted an intensive analysis of data collected by other researchers, such as the Urban Institute's survey of 1,700 hospitals, which focused on the extent of medical care for the poor and the financial status of hospitals serving the poor. A summary of the information we have been developing and analyzing is likely to be helpful in understanding the situation of public hospitals today.

- PUBLIC HOSPITALS ARE IMPORTANT PROVIDERS OF PRIMARY AND AMBULATORY CARE TO POOR PERSONS WHO OFTEN HAVE LITTLE OR NO ACCESS TO PRIVATE PHYSICIANS

NAPH members average almost 106,000 bad debt charity care outpatient and emergency room visits, representing about 50% of all visits at these facilities. These uncompensated care visits are a primary reason that public hospitals average 1.5-3 times the number of visits to all hospitals in the nation's 100 largest cities. The costs for this care are high -- almost $11 million per NAPH institution.

Public hospitals also experience a far higher average level of admissions through the emergency room (over 41% for public hospitals in metropolitan areas, as compared with 25-33% for large city hospitals in general).

In addition to the great burden of outpatient/emergency room charity care currently borne by public facilities in our nation's metropolitan areas, the Urban Institute study finds that high volume providers of care to the poor outside the 100 largest cities are reducing emergency room and outpatient hours or staff at a rate approaching twice that of low volume providers, suggesting that metropolitan public hospitals may have to care for these patients as well.

- PUBLIC HOSPITALS IN METROPOLITAN AREAS ALSO PROVIDE SPECIALIZED TERTIARY CARE, PUBLIC HEALTH AND OTHER UNIQUE SERVICES

These services are often too costly or too "unreimbursable" for most private hospitals to maintain. They include burn units -- trauma centers -- emergency alcoholism, drug abuse, and child abuse centers -- neonatal intensive care -- poison control units -- to name just a few. New Urban Institute data shows that public hospitals with operating deficits in the nation's largest cities were nearly four times more likely to have a burn unit, and about twice as likely to have neonatal, pediatric and psychiatric intensive care units than similarly located private hospitals.

- PUBLIC HOSPITALS CONTINUE TO TAKE ALL PATIENTS -- REGARDLESS OF ABILITY TO PAY

Where public hospitals exist, they are "de facto" national health insurance today. According to a 1983 NAPH survey, uncompensated care represented an average of 29% of 1982 inpatient days for NAPH member hospitals (or an average of 46,010 uncompensated inpatient days per hospital). Forty-six percent of all outpatient/emergency room visits to NAPH members, on average, were also uncompensated (106,000 uncompensated care visits per hospital).

- THE NON-MEDICAID UNINSURED CASELOAD OF PUBLIC HOSPITALS HAS SUBSTANTIALLY INCREASED IN RECENT YEARS

The August 1983 NAPH survey of unemployed and uninsured patients in public hospitals demonstrated that these facilities are now the source of health care for thousands of individuals who had relied on other health services before unemployment. Forty-four percent of the unemployed patients surveyed responded that they had not used the public hospitals as a regular source of care before becoming unemployed. Eight hospitals reporting inpatient and outpatient data had a total of 5506 unemployed and uninsured visits or admissions for a seven day period -- an average of 688 per hospital. If this number as projected is annualized, these eight institutions alone would experience over 280,000 visits and inpatient days by uninsured and unemployed patients.

- PUBLIC HOSPITALS HAVE MANAGED THEIR RESOURCES EFFICIENTLY BUT THEIR VERY MISSION OFTEN CAUSES THEM TO OPERATE AT A LOSS

A recent study by Alan Sager indicates that public hospitals have experienced the largest decrease in length of stay, and the only increase in occupancy rate, among all classes of hospitals in the nation's 52 largest cities. Moreover, public hospitals have decreased their total number of beds between 1970 and 1980 -- by over 22% -- in those cities. In addition, most public hospitals are already managed and budgeted prospectively each year, with full, independent review by state and local governmental entities. Finally, such hospitals are often fully integrated institutions with salaried medical staff, and thus do not present many of the potential problems recognized recently by this Committee in separating hospital costs for physician costs.

In summary, caring for the poor in our nation exacts a high price from our public hospitals -- higher costs, lower compensation and a stressed financial condition. And all of these factors are likely to have a severe impact on the ability of public hospitals to attract sufficient capital to enable them to fill this vital role.

Comments on Proposed Legislation

NAPH strongly supports the principles underlying this legislation. We must emphasize, however, that we believe any ultimate solutions to this problem must necessarily be federal primarily. This population generally fits the mold of what we consider to be a national constituency -- poor, sick, and disabled. We also continue to support a National Health Plan, although we recognize this is currently out of fashion. However, in the not too distant future, we expect to be joined by others in this effort -- for example, by Big Business as their retiree health benefits obligations grow.

NAPH strongly supports the provisions of the bill extending employment-based health insurance coverage for laid-off workers and their dependents, and the creation of subsidized health insurance pools to allow people without employment-based coverage to buy health insurance regardless of their health status. However, the legislation provides for the design and operation of insurance pools to be at the discretion of the States. This flexibility given to the States creates certain problems, such as ERISA preemption, that must be solved if an effective and equitable national program is to be created.

With regard to proposed state systems to fund hospital care for the uninsured, we also support this concept in general, provided that any program give ample recognition to the present reality that there are only a handful of public and private hospitals in most states that presently provide this care.

We are aware of Congress' sensitivity to this as evidenced by the fact that Congress recently passed the Consolidated Omnibus Reconciliation Act of 1986 that provided an adjustment in medicare payments for hospitals serving a disproportionate share if low income patients. We appreciate your efforts Mr. Chairman in obtaining passage of this important legislation.

Under the bill, States must either establish an uncompensated care plan or through an HMO or other mechanism, health care coverage to all residents. Excluded costs for which payment is not provided includes care counted toward a hospital's Hill-Burton obligation, costs "respecting obligations to pay taxes," for "charges that can expect to be collected with suitable bill collection mechanisms," or care provided to Medicare and Medicaid patients. The bill requires the program "to provide for payment for the unreimbursed costs incurred by each hospital in the state in furnishing medically necessary inpatient and outpatient services." The bill gives the state a great deal of flexibility regarding how such costs are to be reimbursed. The only stipulation being that the financing mechanism be "adequate." The enforcement mechanism provided under the legislation would reduce the level of federal financial participation for state Medicaid administrative costs from 50 percent to 25 percent and ultimately to zero.

Our major concern with this legislation is that the method of financing uncompensated care plans should be more clearly delineated. The financing of uncompensated care is a social responsibility. Therefore, the burden of financing care should be shared by hospitals, payers, and all levels of government. Any tax on hospitals could represent a severe hardship on hospitals serving large numbers of Medicare and Medicaid beneficiaries.

The bill lacks precise definition in areas that cause some concern. There is no definition for "adequate" payment levels; there is no standard provided to states to determine exactly what constitutes "unreimbursed costs." NAPH has testified previously that public hospitals providing a high volume of care to the poor have higher costs per inpatient day. This is due primarily to the fact that public hospitals treat more seriously ill patients: patients with multiple diagnosis and those who are victims of infectious diseases, accidents, violence, and substance abuse. A high proportion of these patients overly utilize emergency rooms. In addition, the bill mandates as a condition of payment under the program to a hospital, that the hospital "(i) provide a certain level of charity and unreimbursed care for inpatient and outpatient hospital services and (ii) meet minimum standards in its efforts to collect unpaid bills." These provisions could have the undesired affect of encouraging hospitals not to participate under the state plan for fear of receiving an inadequate state payment for their "unreimbursed costs" with the requirement for a much higher volume of charity care over and above the hospital's Hill Burton uncompensated care requirement. We believe the language of the bill must be clarified to define adequate "payment levels" and "unreimbursed costs." The amount of payment for uncompensated care under the State plan must provide positive incentives for public hospitals to participate and continue to maintain and increase the amount of uncompensated care provided in the past.

We are also concerned that even as they debate this new legislation, HCFA is moving in the other direction, seeking to prevent States from developing pools or providing additional funds to disproportionate share hospitals.

In conclusion, Mr. Chairman, we would like to commend you for taking the initiative in attempting to improve access to health care services for the uninsured and underinsured and view this legislation as an important first step. We look forward to working closely with you to pass this important initiative. I would be pleased to answer any questions at this time. Thank you.

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TESTIMONY OF

John P. Papp, M.D., FACG
President
of the
American College of Gastroenterology

before the

Committee on Labor and Human Resources
United States Senate

concerning

Access to Health Care

July 16, 1986

Mr. Chairman and Members of the Committee, the American College of Gastroenterology commends you for holding these important hearings and for your strong efforts to rectify a crisis faced by so many Americans today. Inaccessibility to health care is indeed a national crisis. As you well know, we are not talking about access to quality health care - we are talking about access to any health care. Today, 37 million Americans have no health insurance. In most cases, they have no health insurance either because they cannot afford the high premiums or because they have a pre-existing condition which prevents them from being able to obtain health insurance. Not only does this pose a devastating financial problem for many Americans, but it has been estimated that approximately one million Americans are refused medical treatment because they cannot afford to pay for it.

The American College of Gastroenterology considers the Access to Health Care Act of 1986 a critical step towards assuring the availability of health insurance to all Americans, particularly those most in need of coverage. The legislation's provisions to strengthen employment-based health insurance pools, establish subsidized health insurance pools, and develop a mechanism for state funding of hospital charity and unreimbursed care provide a viable solution to this national crisis.

The American College of Gastroenterology strongly supports the Access to Health Care Act of 1986 and commends Senators Kennedy and Druenberger and the other co-sponsors of this legislation for their strong leadership and firm commitment to alleviating the devastating problem of inacessible health insurance.

National Organization for Rare Disorders Inc.
NORD • P.O. Box 8923 • New Fairfield, CT 06812 • 203/746-6518

July 15, 1986

Senator Edward Kennedy
Senate Labor & Human Resources Committee
Hart Senate Office Bldg.
Washington DC 20510

Dear Senator Kennedy:

The National Organization for Rare Disorders (NORD) would like to submit the attached written testimony for inclusion in the record of the July 16, 1986 hearings on S.2403. The legislation concerns the creation of "High Risk Health Insurance Pools," a topic of utmost interest to 20 million Americans with rare, chronic and debilitating "Orphan Diseases."

We would be delighted to work with your staff in the future concerning this matter, since the unavailability of health insurance to people with pre-existing conditions is a matter of life and death to the people we represent.

Very truly yours,

Abbey S. Meyers

Abbey S. Meyers
Executive Director

ASM:sb

cc: Mr. Richard Nugent
Epilepsy Foundationn of America

Ms. Myrl Weinberg
American Diabetes Association

Senator Orrin Hatch

Honorary National Chairman
Jack Klugman
Member Organizations
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Ehlers Danlos National Foundation
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International Rett Syndrome Association, Inc.
Interstitial Cystitis Association
Mucopolysaccharidoses Research Funding Center
Narcolepsy Network
National Association for Sickle Cell Disease, Inc.
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National Gaucher's Foundation
National Head Injury Foundation
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National Ichthyosis Foundation
National Marfan Foundation
National Multiple Sclerosis Society
National Neurofibromatosis Foundation, Inc.
National Retinitis Pigmentosa Foundation
National Tay Sachs & Allied Diseases Association
National Tuberous Sclerosis Association, Inc.
Osteogenesis Imperfecta NCA Inc.
Paget's Disease Foundation, Inc.
Parkinson's Disease Foundation
Parkinson's Educational Program (PEP•USA)
Polycystic Kidney Research Foundation
Prader Willi Syndrome Association
Scleroderma Info Exchange
Scleroderma Society
Sjogren's Syndrome Foundation
Tourette Syndrome Association, Inc.
United Leukodystrophy Foundation, Inc.
United Parkinson Foundation
United Scleroderma Foundation, Inc.
Williams Syndrome Association
Wilson's Disease Association

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Ohio Tourette Syndrome Association
Research Trust for Metabolic Diseases in Children

*Associations are joining continuously. For **newest** listing contact the **NORD** office

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STATEMENT OF
THE NATIONAL ORGANIZATION FOR RARE DISORDERS (NORD)

To the Senate
Labor and Human Resources Committee

For inclusion in the hearing record concerning S.2403
July 16, 1986

Contact Person: Ms. Abbey S. Meyers
Executive Director
National Organization for Rare Disorders (NORD)

Dedicated to Helping People with Orphan Diseases

NATIONAL ORGANIZATION FOR RARE DISORDERS (NORD)
TESTIMONY
Access to Health Care Act (S.2403)

The National Organization for Rare Disorders (NORD) is a national non-profit voluntary agency representing the interests of an estimated 20 million Americans afflicted with rare, chronic "Orphan Diseases." An Orphan Disease, as defined under PL97-414, is an illness affecting fewer than 200,000 Americans at any given time. Because these low incidence disorders do not affect large populations of people, research into their cause and cure is generally a low priority to scientists and the pharmaceutical industry.

NORD is intensely concerned about the unavailability of health insurance to people with pre-existing conditions. We feel that the most humane and equitable solution to this tragedy is a national health insurance plan, available to **every** American. Costs should be spread evenly throughout society and people with serious health problems should not be penalized financially for their suffering. However, in lieu of this ultimate solution, we support S.2403 as an interim measure which will alleviate the suffering of **some** Americans who can afford to pay the inflated premiums of high risk health insurance pools.

We feel that the Senate should review the high risk pools operating in several states now, in order to determine whether they inadvertantly create an inducement for health insurance companies to "dump" minimal risk persons into the pools. We suspect that some people with minor pre-existing health conditions who do not require exceedingly high medical expenses, may be denied mainstream health insurance in some states simply because health insurers hope that by adding lower risk individuals to the high risk pool, the year end deficit may be lowered. If this can be documented, we would ask the Committee to guard against this practice by revising S.2403.

Additionally, we are concerned that some people, who are not eligible for Medicaid due to family income which is barely above minimum, cannot afford to purchase health insurance at normal rates. Therefore we question how they will be able to afford premiums costing 150% of the average health insurance policy sold in that State. We feel that this stipulation may prohibit many persons, most in need of medical insurance, from obtaining coverage.

The cost of high risk health insurance premiums is probably the primary reason that high risk health insurance pools existing today are underutilized. However, we cannot suggest options which would lower the premiums unless the cost were to be spread throughout society. We do not feel that employers should be financially penalized for this tragedy. Indeed, we believe that health insurance should **not** continue to be related to employment in America. Health insurance should be made available to **every** American with or without a serious health condition, and regardless of their employment status.

We feel that the major populations affected today by the unavailabiity of health insurance (and its inseparability from employment) are:

1) People with pre-existing conditions, and

2) Women who, through no fault of their own (i.e., divorce or death of a spouse), find themselves without health coverage. Health insurance is so deeply entwined with employment in America that many women, even if they are employed, rely solely on their husband's health insurance which can be discontinued at any time.

Furthermore, although the health insurance industry insists that the great majority of Americans are covered by family health insurance policies through an employer, they do not take into account how many family policies do **not** cover the wife or a child because of a pre-existing condition. The letters we receive from the public indicate that many families with full health insurance coverage are suddenly told that one or more members of a family will no longer be insured. This often occurs at the time when the dependant is most in need of coverage...when they are sick! **It should be illegal for a health insurer to provide "family" coverage when one or more family members are excluded from the health insurance contract.** We find this practice to be particularly immoral when unaffected siblings of a child with a genetic disorder are denied health insurance on the presumption that they **may** get the disease.

We are reminded of the story of the young man walking along the beach after a storm, picking up starfish and flinging them into the water. An older man asked him why he was doing this, and the young man answered that the starfish would die if left stranded on the beach in the morning sun. "But the beach goes on for miles, and there are millions of stranded starfish," the old man said. "How can your effort make any difference?" The young man looked at the starfish in his hand and threw it to safety in the sea. "It makes a difference to this one," he said.

We feel that S.2403 **will** save **some** stranded starfish, at least those who can afford to pay the premiums. We would like to see **all** of the starfish saved, but this will require an army of compassionate Americans and the backing of the Federal government. If S.2403 can save **some** people from unneccessary suffering and death, we support it, but we cannot stop ourselves from grieving for those who will remain stranded on the beach in the morning sun.

STATEMENT

OF THE

AMERICAN RENTAL ASSOCIATION

IN OPPOSITION TO

THE ACCESS TO HEALTH CARE ACT
S. 2402

BEFORE THE

SENATE LABOR AND HUMAN RESOURCES COMMITTEE

OF THE

UNITED STATES SENATE

September 5, 1986

STATEMENT
OF THE
AMERICAN RENTAL ASSOCIATION
IN OPPOSITION TO
THE ACCESS TO HEALTH CARE ACT
S. 2402

The American Rental Association ("ARA") is a national trade association, comprised of over 4,000 independent member firms engaged in the business of renting diverse items of equipment and other personal property to the public. Our national headquarters is located in the ARA Building at 1900 19th Street, Moline, Illinois 61265. ARA is in its 31st year of operation, and is the sole organization representing the industry of equipment rentals on a national basis.

ARA member firms rent a wide variety of equipment and personal property, including such lines as homeowner items; party supplies and equipment; construction machinery and equipment; vehicles and other mobile equipment; medical equipment and devices; and exercise and recreational equipment.

In 1976 the United States Department of Commerce estimated the equipment rental industry to include 10,000 equipment rental outlets in the United States.[1] That number is considerably greater in 1986. These firms are primarily small business firms usually comprised of 4-10 employees.

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[1] See Equipment Leasing and Rental Industries: Trade and Prospects, U.S. Department of Commerce, December 1976.

The American Rental Association is opposed to "The Access to Health Care Act", S.2402 as well as any government mandated employee benefits for the reason that it is destructive of the collective bargaining process.

More specifically, we suggest the following:

> Risk pools of some nature may conceivably be one appropriate response to the problem of providing coverage to medically uninsurable individuals. However, attaching such a far-reaching health policy proposal to a budget reconciliation bill or rushing its consideration without further study is both unwise and hasty.
>
> The proposed legislation, offers very loose guidance on the types of benefits that would be provided by a pool. The states might well extend beyond providing core medical benefits, or could charge very low premiums and then require employers to pay the cost for these expensive benefits.

Requiring employers to subsidize the financial shortfall in the pools forces businesses to pay for health care coverage for non-employees. This added burden is a disincentive for employers to voluntarily assume the cost of offering health care coverage to employees and their families by offering health plans at all.

The responsibility for ensuring care to medically uninsurable people is a societal burden we all share. There is no justification for imposing the burden only on businesses, especially when employers already account for 85% of the nation's private health care coverage.

We hope that you will take these points into consideration and reach the same conclusion that we have. Governmental mandates of employee benefits to employers is wrong and exhibits yet another attempt by the federal government to invade private relationships in which it has no valid right or reason. Benefits should be left to the time-honored collective bargaining process.

U86/027

Senator KENNEDY. The committee will stand in recess.

[Whereupon, at 12:15 p.m., the committee was adjourned.]

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